Vol. 5, No. 1 February, 1958

lcoholism

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This periodical is published five times a year in the interests of a deeper understanding of the widespread disorder alcoholism.

Each issue contains pertinent, factual information selected primarily because of its interest to those who are called upon to deal with alcoholism professionally. Articles published do not necessarily represent the views of the Foundation.

If you would like to receive this publication regularly, or if you wish additional information about some aspect of alcoholism, you are invited to write to the Alcoholism Research Foundation, 9 Bedford Road, Toronto 5, Ontario.

Circulation of this issue: 1

Vol. 5, No. 1
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RESEARCH

TREATMENT

EDUCATION

Reconsider alcohol teaching problems

Variety and change in social attitudes major factor in defining school's roles

*By Raymond G. McCarthy**

DURING the last decade considerable attention has been devoted to the social problem of alcoholism. Five Canadian provinces as well as more than two-thirds of the states of U.S.A. have passed legislation creating some kind of agency to deal directly with the problem through treatment services or through education. As public awareness of alcoholism as a health issue has increased, attention has been directed toward prevention. In particular, attention has been focussed upon the role of the school.

Alcoholism is a social problem and social problems are always

Raymond G. McCarthy is Associate Professor of Health Education at Yale University and Associate Director of the Yale Summer School of Alcohol Studies. *This article is part of a talk he gave to a workshop on alcohol education at the 1957 Ontario Association Convention, Toronto.*

complex. Whether you are dealing with delinquency, race prejudice, crime or divorce, there is always a body of facts, a body of data. There is in addition, a body of attitudes. The attitudes are culturally determined and interpretation of the data is colored by feelings. Where attitudes dominate a situation, changes do not ordinarily come about in response to logic.

Social Attitudes

There is a considerable body of information available about alcohol and its effects upon the individual and upon society. In what follows we are particularly concerned with the nature and extent of the attitude about drinking customs in our societies and the educator's relation to these attitudes. Unless we can analyze and develop an approach to attitudes about drinking we are not likely to make very much progress in dealing purely with information.

Most of us derive our information about drinking initially from family, from neighborhood associations and from the church. Because of the controversy over prohibition in the U.S.A. and Canada, there have developed barriers to understanding between those who look upon alcohol as a threat to individual and social existence, and those who see in the controlled use of alcohol a resource making for an increase in the satisfaction to be derived from social relations. It is estimated that approximately two-thirds of the adult population in the States and also in Canada use alcholic beverages at some time during the year. One-third of our people do not drink at all, either because of religious conviction, for reasons of health or general indifference.

Those who oppose the manufacture and sale of alcoholic beverages are organized and are in a position to publicize their opinions. School legislation requiring instruction about alcohol was enacted years ago in many areas by those who were sympathetic toward total abstinence. I think it is possible to demonstrate that there was much wider acceptance of the principle of total abstinence fifty years ago than exists in our society today. Changes have occurred in drinking customs —changes which involve more widespread acceptance of the custom by women, and by young people. Recent studies in high schools in New York, Wisconsin and Kansas reveal that more than half of the young people participating in the surveys used alcoholic drinks, and a substantial number do so with parental permission.

Develop Objectivity

That there are excesses associated with the use of alcoholic beverages by many drinkers is quite obvious. That these excesses inevitably follow the use of alcoholic beverages has not been established. The development in the classroom of an objective consideration of alcoho-

ON KNOWING WHAT YOU ARE TALKING ABOUT

In many instances where people are discussing the pros and cons of controversial problems, one main reason for lack of any degree of agreement of understanding is because the discussants are not all talking about the same thing. This is often true with alcohol studies. The teacher should make it clear to the pupils which aspect of alcohol studies is being considered — legal use, illegal use, non-alcoholic excessive use, mal-use, or alcoholic excessive use.

—Arthur J. Giovannangeli, Ed. D.*

**from article, Schools Can Help Cut Alcohol Problems, reproduced by permission in the November 1956 issue of ALCOHOLISM.*

ıse and abuse in our society is ıandicapped by misinformation and olk lore handed down from one ;eneration to another.

School's Position

What is to be the school's posiion now that increased pressure is ›eing brought to bear upon adminstrators and teachers to assure a nore active role than they have demonstrated in the past? It seems to ne that we must acknowledge that ve live in a society in which cultural attitudes toward the use of lcoholic beverages are strong. We nust recognize also that to follow he traditional teaching approach of mphasizing only the threat of hysiological harm from drinking s likely to be ineffective inasmuch s this threat has been rejected by he majority of drinkers. To conlemn or to sanction drinking pracices is in my opinion outside the esponsibility of the public school. believe that we must accept the luty of dealing with this controverial issue in the same manner that ve deal with other difficult issues. We must adopt an objective approach which has for its goal to interpret to young people the society in which they are going to function and in which alcohol use is widely accepted. I do not consider this a defense of drinking or of not drinking. I believe it constitutes a defense of objectivity, of intellectual honesty in the classroom.

Much might be said about the effectiveness or lack of effectiveness of traditional teaching about alcohol. I would say about 90 per cent of the teaching about alcohol in the schools in the past emphasized total abstinence. Yet 68 per cent of the adult population of the country today use alcoholic beverages. One study showed that the highest incidence of use of alcoholic beverages was in the age range 20-29 years. This is not alcoholism—this is use. This is the age range most recently exposed to the influence of the school.

Effectiveness

By educational classification those with high school experience or better showed a higher incidence of use. I leave to you the judgment of the effectiveness of traditional

teaching about alcohol. Yet we cannot judge the effectiveness of the school without considering the community, the family, the changing culture in which we live. The effect of the primary group in establishing certain attitudes is of tremendous significance. I suspect that the school during the last twenty-five years has been moving away from the primary groups, has been growing apart from them, so that there is not only a lag in some of our teaching approaches but there is a kind of a blocking between the school and the community.

Physiological Approach

The traditional teaching approach has been physiologically centred. I think that we might also say it was based on a psychology of fear, of threat. It was negativistic. "If you drink, you'll become insane. It you drink, you'll get liver cirrhosis; if you drink, you will deteriorate socially." The fact that these dramatic changes were not apparent among most drinkers, seemed to reflect on the validity of the statements. It produced some confusion in the minds of the students. They may have lost some respect for the school. It certainly did not give the young person a positive approach to the question.

The emphasis in the biology and physiology classes in the past has made for a restricted interpretation of the personal and social implications of drinking. I have no objection to the material in biology texts. Much of it is excellent. However, too often it remains at the physiological level and never moves into the social level. Moreover, so long as administrators kept it at that level, they could in a sense avoid the controversial element, the political element, questions of religious differences and attitudes.

Much of our teaching has been developed around adult aims and goals. These are worthy, admirable, highly to be desired. Nevertheless there is some question how effective they have been with young people.

Conflicts

The emphasis on teaching total abstinence as the only alternative has been in conflict with what young people saw among adults—in their own families and among other families. The implication that drinking is always disreputable was in conflict with what they observed among people whom they considered reputable. Adults disregard the physiological threats which the school taught as established facts. Even the child who could accept

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he teaching was left with a feeling f uncertainty about his own amily, about his friends.

Not all churches have insisted n total abstinence. How can you et up a single approach when you ave wide group differences within our classroom? Not all teachers ccept the principle of total abstinnce. And there are wide divergences among social groups conerning drinking practices and total bstinence.

A most serious weakness in traditional teaching was that it was ot based on student needs. I think ood teaching usually suggests beinning where the group is and noving on from there. Adolescent eeds are tremendous, the need to e accepted, to be independent, to e an adult. Accompanying these trivings for independence and dulthood, exist strivings to remain lose to the family, to be dependnt; uncertainties about self, about hysical and psychological changes, ormonal changes. For many adoescents the potential use of alcohol s a question of not being different, f being accepted—of being daring nd adult.

Selected Facts

What can we teach? The concept f alcohol as an anesthetic might vell be introduced—that it is not a timulant, that it is not a dehydrant t low concentrations, that the conentration in the body even in a leeply intoxicated man, is less than fraction of one per cent. It should be emphasized that many of the theories about coagulation, about deterioration of the fatty sheath around the nerves need to be questioned. Certainly there are bodily disturbances associated with uncontrolled drinking. Whether they result from vitamin deficiency or some other cause is secondary to establishing the facts. I don't consider that this constitutes a defense of alcohol or its use. We have a responsibility to support a defence of science, of medicine, of objective teaching.

Student Interests

I believe we can teach many basic facts about alcohol and its effect on the individual. For example, we can do a lot with the question of alcohol and traffic. High school students are eager to get a licence, to drive a car. It is a golden opportunity to introduce material on the action of varying amounts of alcohol on reflexes.

I believe we should provide an opportunity for full and uninhibited discussion in the classroom about this question of drinking. I have said that a negativistic approach is not psychologically sound. Attacking drinking customs is not necessarily the most effective approach. Boys and girls are going to get information about drinking from some source. It may not be the kind of information that makes sense to the adult. It must be at the level of young people because that is the only kind that makes sense to them

and their friends.

I think we need to consider the needs of young people—to be accepted, to be popular. Is it sophistication, or is the boy who insists on engaging in a bizarre drinking episode indicating his insecurity, his feelings of inadequacy, by trying to attract attention?

Integration Question

As far as grade placement is concerned, I don't think we can do very much in the early grades other than to incorporate it with information about eating and drinking habits. For young children certain foods, certain drinks are not recommended. At the secondary grades we can do more. I don't think there should be any formal courses. I don't know where you would place a formal course. We have had enough compartmentalization of education as it is. Wherever possible alcohol instruction should be integrated with other courses. Now I recognize some of you are thinking that integration of teaching leads to incidental teaching. This need not be the case. We can furnish teachers with material in which they have confidence, material which will evoke an active response from students.

How far do we go? I think we should start teaching at the point where the students are, not where we would like them to be. There is a challenge in this type of teaching which is being met in many schools in such courses as home and family living, home management courses for boys and girls, questions about the function of the family, of society, the role of parents. Such material is being introduced in schools around the country. We can encourage consideration of the advantages of abstinence for young people rather than the threat of drinking. Actually the threat to young people is not insanity, not cirrhosis, not alcoholism. The real danger for young people is intoxication. At an age when physical and emotional balance has not been established, when spurts of one kind or another occur, when there is tremendous concern on the part of many people over emerging adulthood, we may well hesitate to introduce into the system a chemical which may retard their advance to emotional balance.

Group Interaction

We can only achieve open-mindedness in discussion of alcohol questions in the classroom when we give up the traditional assignment, question and answer approach and rely on group interaction. There is evidence that young people in a permissive atmosphere will be completely honest, will be completely relaxed in expressing opinions. When the teacher accepts her role as group leader, when she is willing to give up her authoritarian position, when she is willing to place confidence in the group to direct its discussion into constructive channels, I believe that results will be illuminating.

Relate to Goals

The World Health Organization Expert Committee on Health Education of the Public stresses the importance of motivation in learning, including the need to satisfy goals and interests and the significance of the group approach. "People are interested in doing those things which seem to help them achieve something they want, or to cope with their own specific problems." The health educator who recognizes this characteristic of learning will not ask, "How can I motivate people to learn about health and to change their health practices?" Instead, he will be concerned with the goals and purposes of the people; how he can help them obtain their goals, and perhaps see a relationship between some of their goals and improved health practices.

The use of alcoholic beverages has persisted in our culture because it serves a function and presumably assists some people in attaining certain goals. Acceptance of this premise as a basis for exploring questions about alcohol does not imply that the function or values involved are either worthy or disputable. Attacking drinking customs constitutes an attack upon the goals of many drinkers, goals which in themselves may be admirable. This usually results in rejecting the charges presented in the attack and strengthening defenses against future attacks.

Such an approach to instruction in a controversial area is extremely difficult. It calls for a degree of personal maturity, objectivity, and patience of a high order. This procedure applied in the field of alcohol problems will be subject to criticism. Some church leaders will challenge it on the ground that it endorses the principle of relativity of morals. Some professional propagandists, on the contrary, will consider it lukewarm, negativistic, and unlikely to produce immediate results. Still others will feel that it condones "moderation" and as such espouses the cause of the alcoholic beverage industry.

Explore Continuum

It is difficult to comprehend how a public school administrator or teacher can assume any practice other than one of objective analysis of all the facts. This is not fence-straddling—there is no fence except the one erected by extremists. Rather there exists a continuum of fact and attitude which should be explored. This is the most constructive and probably the most productive approach that can be taken in the classroom.

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WHAT ABOUT DRINKING?
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Jellinek's phases useful in therapy*

Parallels to patients' own experiences help them accept selves as alcoholics

THE idea of phases in the development of alcoholism, as first formulated by E. M. Jellinek in 1946, and elaborated in 1952, has recently been put to use by both research and clinical workers in the field.

"Pre-Alcoholic"

According to Jellinek, alcoholism begins with the "pre-alcoholic" phase: The individual advances from occasional to constant "relief" drinking. Either because his tensions are particularly severe, or because he is unable to handle them, he experiences a strong and rewarding sense of relief from tension in drinking situations. Toward the end of this phase his tolerance for alcohol increases; the same amount of alcohol seems to affect him less than formerly.

"Prodromal"

Alcoholic "blackouts" mark the beginning of the "prodromal" phase. The drinker wakes one morning and cannot remember what happened after a certain point the night before. Normal drinkers sometimes have this experience; but if it happens repeatedly, or after only a moderate intake of alcohol, the development of alcoholism is indicated. The role of alcohol in the drinker's life now changes from an enjoyable beverage to a needed drug. He becomes preoccupied with getting enough to drink; he "sneaks" extra drinks at a party; he begins to avoid conversation about alcohol.

"Crucial"

The "crucial" phase starts with "loss of control": At this stage any intake of alcohol may evoke in the alcoholic what he feels as a physical demand for more. He cannot be sure, if he takes one drink, that he will be able to stop. He begins to rationalize his drinking behavior, blames others for his problems, behaves aggressively toward them. At the same time his self-esteem suffers; and while outwardly he compensates for this with grandiose behavior, inwardly he suffers from severe remorse. He tries "going on the water wagon," or changing his drinking pattern. As these measures fail, he changes tactics, drops

(Continued on page 13)

A.R.F. ACTIVITY NEWS

FEBRUARY 1958

APPOINT EXECUTIVE SECRETARY FOR NEW HAMILTON A.R.F. BRANCH

Gordon M. Patrick, former head of the East York Y.M.C.A. and previously of a Vancouver Y.M.C.A., has been appointed Executive Secretary of the recently formed Hamilton branch of the Alcoholism Research Foundation.

Mr. Patrick begins work organizing facilities and services for the new Foundation Branch in late February. Plans call for establishment of an out-patient counselling service as soon as suitable quarters can be found. Arrangements have also been made for two beds to be available at Hamilton General Hospital for referred cases needing hospitalization.

The new A.R.F. Branch, fourth to be established outside of the Foundation's central facilities at Brookside Clinic, Toronto, is being directed by a local board of the following directors: W. D. Parker, Q.C. (Chairman) ; Dr. G. P. Gilmour, Rev. T. R. Davies, Messrs. Murray Tallman, Ralph Sazio, Sheldon Foley and Tom Jarvis.

FOUNDATION LOSES PIONEER EDUCATION DIRECTOR.

Robert R. Robinson, who became the first full-time Director of Education for the Alcoholism Research Foundation in 1953, accepted in late 1957 the position of Co-ordinator of Public Relations for A. V. Roe Canada Limited and has therefore resigned from the Foundation Staff.

The A.R.F. educational work as presently carried on is largely the outcome of Bob Robinson's pioneer work. His cre-

ativeness and his awareness and sensitivity to the needs of various audiences have made a marked impression on programs of alcoholism education not only in Ontario but in many other parts of Canada and U.S. His former associates sincerely regret the loss of his full-time counsel but wish him the best of success in his new endeavours.

RE-ORGANIZE EDUCATION DEPARTMENT

Two new head office staff positions have been created within the Alcoholism Research Foundation to take over and expand the work of the Foundation's former Education Director, Robert R. Robinson.

Wm. J. Wacko, former Executive Secretary of the A.R.F. Ottawa Branch has been named Chief, Special Education Services, and Vernon Lang has joined the staff as part-time information Officer.

Mr. Wacko will develop the group teaching and study course side of the Department's work, while Mr. Lang will handle A.R.F. publications and liaison with mass media. The current issue of ALCOHOLISM is the first to be published under these new arrangements.

NEW FOLDER ON 13 STEPS HAS HINT FOR HOSTS

"If food you were serving threatened one of your guests with serious illness (as sugar might a diabetic) would you expect him to eat it? No, you would considerately offer him a choice of other food that would not make him sick."

These are the opening words inside **R.S.V.P.** (Reasonable Solution to a Vexing Problem), a new A.R.F. folder 4" x 5½" prepared by former A.R.F. Education Director, Robert R. Robinson just before he left for his new job in industry. Available for mass distribution in Ontario it opens up to a descriptive list of the well-known "13 Steps to Alcoholism."

COMPLETE SECOND SERIES OF CLERGY SEMINARS

The second series of clergy workshops on alcoholism was held this fall co-sponsored by the Christian Social Council of Canada and the Foundation. There were 14 participants with an average attendance of ten clergy during the six half-day sessions.

Several members of the treatment staff presented such aspects of treatment as identifying the problem, introducing treatment, and assisting the alcoholic's family. The last two workshops focussed on prevention, with a discussion of attitudes and use of films with church groups.

Most of the clergy gave expression to the ways in which the workshops were helping them in their pastoral ministry, and the Council has requested a similar series for the fall of 1958.

NEW FACILITIES AND HEAD FOR OTTAWA BRANCH

John A. Neilson has succeeded Wm. J. Wacko as Executive Secretary of the A.R.F. Ottawa Branch. New and expanded quarters have been obtained for the Branch at 1206 Bank Street, Ottawa.

The Ottawa General Hospital is now providing two beds for A.R.F. referred patients in addition to those already being used at Ottawa Civic Hospital. Hospital treatment of patients at the Ottawa General will be under Dr. O. Bedard.

Arthur D. Lunt, M.B.E.

The Alcoholism Research Foundation deeply regrets the passing of Arthur D. Lunt, M.B.E., one of its most devoted Members. His fine business ability, coupled with his humanitarian approach to the problems of the people he served, earned our deepest respect.

RECENT ARTICLES BY A.R.F. STAFF MEMBERS

Alcoholism and Nursing (Canadian Journal of Public Health, Sept. 1957). and **Alcoholism and Probation** (Federal Probation, Sept. 1957), both by Miss R. Margaret Cork, Chief Psychiatric Social Worker, Brookside Clinic. These articles, of which reprints are available from the Alcoholism Research Foundation, show clearly the various ways in which members of the two professions concerned can fit more successfully into the teamwork involved in the rehabilitation of alcoholics.

The Protective Drugs In The Treatment of Alcoholism (The Canadian Medical Association Journal, Aug. 1st, 1957) by John D. Armstrong, M.D., Medical Director, A.R.F., deals with the use of disulfiram (Antabuse) and citrated calcium carbimide (CCC) in treatment of alcoholics. It is essentially a review for physicians of the clinical uses of these drugs and their relative merits for different cases. Both drugs produce unpleasant reactions in the patient when followed by alcohol, knowledge of this fact by the patient being an important deterrent to resumption of drinking. CCC has been developed by A.R.F. research under Dr. J. K. W. Ferguson and is free from certain side effects which disulfiram produces in some patients. (Reprints available).

The Search for the Alcoholic Personality (Annals of the American Academy of Political and Social Science, January, 1958) by John D. Armstrong, M.D., Medical Director, A.R.F. Dr. Armstrong reviews the efforts to date to isolate a particular type of personality that might be shown to be susceptible to alcoholism. He discusses limitations in methods used to date and concludes that "the search has just begun." The article is one of 16 contributions by various competent specialists to a 200-page volume on **Understanding Alcoholism** which is something of a landmark in the field: it reviews all phases of present North American knowledge of this subject.

friends, quits jobs, possibly moves to another town. Gradually his interests aside from alcohol decline; strong self-pity is evident; proper eating is neglected; and morning drinking may become habitual. About this time he may first be hospitalized for an alcohol-related complaint.

"Chronic"

The "chronic" phase is introduced by the first prolonged alcoholic bout or "bender": days or weeks are spent just drinking, heedless of responsibilities or consequences. Typical of this phase are ethical deterioration, indifference to the kind of drinking companions, drinking non-beverage alcohol, and sometimes the occurence of alcoholic psychosis. Vague fears and physical tremors are persistent. Drinking becomes obsessive. His rationalization system fails and the alcoholic admits defeat. At this point he is most amenable to treatment.

The possibility of using the phases concept to formulate an objective definition of alcoholism has been explored systematically by J. L. Jackson (Seattle). Definitions up to now have largely relied on the degree of social disorganization and on the amount of drinking, rather than on specific symptoms of the disease itself. There are two main problems connected with this kind of definition. First, it brings a great deal of subjectivity into the decision on whether the patient is an alcoholic and especially on the question of how severe the disease is. For instance, the opinion of a clinical worker who is a regular drinker differs substantially from that of an abstainer as to whether a given amount of drinking is excessive. Second, the alcoholic's rationalization system can usually handle evidences of social disorganization and excessive drinking; he thus remains unconvinced by this definition of his illness and avoids treatment.

Jackson's proposed objective definition of alcoholism is based on personal symptoms of behavior and attitude. Items relating to these symptoms were selected from the Jellinek Drinking History questionnaire and arranged in two scales: The Scale of Preoccupation with Alcohol, and the Scale of Psychological Involvement. These scales measure progression from least to most deviant behavior.

Use of Scales

In the counseling situation, Jackson found the phases questionnaire and the scales extremely useful. The questionnaire focuses immediate attention on the main problem, drinking, which the alcoholic is ordinarily adept at avoiding. In the face of almost 100 experiences connected with excessive drinking, many of which he must admit having had, his rationalization system begins to fail him.

Defies Rationalization

When he is presented with an analysis of the pattern of his disease in terms of either the Jackson scales or the Jellinek phases, the objective proof again defies rationalization. Confronted with these instruments, patients not only accepted their disease more readily but became concerned about the possibility of developing the further symptoms outlined in the scales or phases. Such concern is, of course, invaluable in promoting recovery. Besides convincing the alcoholic of his disease, this technique, after further research, may permit earlier diagnosis and give the counselor an idea of the severity of the illness and of just what this stage entails in terms of social and psychological experiences.

The Jellinek phases have been used as a basis for group counseling by D. Stewart (Fredericton, N.B.). The group evaluates its former behaviors, using a list of 10 symptoms (such as sneaking drinks, alibi making, expansive behavior) as jumping off points for discussion. The patients thus develop insight into and understanding of the alcoholic pattern of behavior, with therapeutic effect.

C. S. Clifton (University of Oklahoma) has used the Jellinek phases in the initial interview with alcoholic patients. After affirming the disease concept of alcoholism, he outlines the steps in its progression in the form of a story about a hypothetical alcoholic. As the narrative advances through the phases, the patient recognizes his own story and begins to supply much of the content himself, filling in the outline of the phases. The patient is less likely to reject recognition of his detailed alcoholic experiences than the bare idea that he is an alcoholic. Ideally, patients leave this type of interview with their initial hostility and fear overcome.

The fact that several therapists have independently discovered the usefulness of the Jellinek phases in the early treatment situation seems to support Jackson's view that further research and experimentation is warranted to exploit the full potentialities of the phases concept.

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Alcoholism understood differently in different countries

International variations in problems of Alcohol as noted in work of E. M. Jellinek with world health organization

IN considering alcoholism internationally, great care must be taken to understand what different authorities mean by various terms that are commonly used. Alcoholism, for example, means one thing to a Canadian student, another thing to a French student and still another thing to a student of this field in Finland. The greater part of the literature on alcoholism is of North American and British origin. In these nations the psychological and psychiatric aspects of alcoholism are so much in the foreground and engage the interest of the student of alcoholism to such a degree that the terms "alcoholics" and "alcoholism" are applied only to those excessive drinkers whose steady uncontrolled drinking is believed to be of psychological origin.

Occasional Excess

However, in many countries serious problems of national magnitude arise more from other types of drinkers than from the steady, excessive, symptomatic drinkers. Alcoholics of the latter type do, of course, exist in every country where alcoholic beverages are consumed but they may form such a small group or, even if they reach a fairly large number, the problems arising from them may be overshadowed by the problems which heavy occasional drinking presents.

Finland

In Finland, for example, the violence displayed by Finnish workers when they come to town from some isolated lumber camps and have a few drinks causes such damage and is so dramatic that to the Finnish nation this type of drinking and this form of damage constitutes alcoholism.

Alcoholics, as North Americans know them, are by by no means absent in Finland and they resemble in their behaviour their Canadian, American, British and Swedish brethren; but their slowly drinking themselves to death seems to present less of a problem than the violence (knifings and slashings) and other damage caused by the occasional explosive weekend drinker.

By the same token, one may

suspect that the great number of alcoholics in Canada and the United States and our preoccupation with this problem may lead some students of alcoholism here to underestimate and to ignore the damage arising from occasional excess and other associated problems.

France

The French picture, on the other hand, is quite different from either the North American or the Finnish. There is in the French literature on Alcoholism frequent mention of "l'alcoolisme sans ivresse" (alcoholism without drunkeness.) It is asserted by students of this subject and the citizens of France that a drinker can become an alcoholic without ever showing signs of intoxication. This can sound incredible to North Americans but when one observes French drinking habits this contention seems quite plausible. In the past few years the average *daily* consumption of *pure alcohol* from wine and other alcoholic beverages for adult French males was equivalent to 4.3 ounces. This is a medium-sized glass tumbler full of pure ethyl alcohol.

The outward manifestations of intoxication, however, are rarely seen in France on the average. This is presumably because the consumption is spread throughout the day, beginning with breakfast, and thereafter small amounts at intermittent periods until bedtime. For example, at no time during the day are particularly large amounts consumed so that, according to Jellinck, the blood alcohol concentration will range from .02% to .12%, but rarely above that.

French drinkers may carry on like this, on the average, for 15 or 20 years before the organism breaks down and the disease of chronic alcoholism—i.e. Cirhossis of the liver, etc.—appears.

There is in France, a general rejection of the idea that alcoholism is related in any way to psychological and emotional maladjustments.

The French attribute their type of "alcoholism" entirely to social habits and attitudes which are greatly influenced by economic factors. We attribute ours to alcoholism superimposed on an emotionally unstable personality.

Economic Factors

The economic factors involved in this problem require a great deal of study and should be carefully considered by all students of this field. In France viticulture constitutes a highly important part of the country's agricultural wealth and millions of its inhabitants earn their living through the production of the raw materials, and the processing and sale of alcoholic beverages. The vested interests of these groups do contribute toward a general acceptance of large consumption. There exists an identification of the general population with these interests, which are recognized as national ones.

Italy Different

In Italy, on the other hand the roportion of arable land under iticulture is actually larger than in rance. Nevertheless, the Italian coholism rate is about one fifth at of France and the consumption f total alsolute alcohol per head half that of the French. Also the attern of drinking in Italy differs eatly from the French pattern: rinking is restricted almost entire- to meals and distilled spirits ay an insignificant role. Yet, in rance, where distilled spirits con- ibute 14 per cent toward the total cohol consumption, this latter pe of beverage nevertheless has a rger consumption-rate per head an in countries where it is the edominant source of alcohol (e.g. nland, Sweden, Norway).

Again, considering the role of onomic influence, in Sweden the overnment monopoly is devised to iminate the element of profit. Yet the problems of alcohol there are much greater than in Spain or Italy with their great economic investment in production of wines.

Weigh All Factors

These facts indicate that the economic interest alone cannot account for the extremely high alcoholism rate in France, but there must be some differentiating factors between France and other large wine-growing countries with marked vested interests. These differentiating facts must be in the nature of cultural patterns as well as collective and individual psychological elements. We should be careful to note, however, that the singling out of any one specific factor at this state in our developing knowledge, and attributing a complete cause and effect relationship to that factor tends to obscure the issue. All factors must be brought into perspective.

lcohol-epilepsy link still uncertain

Need more electroencephalograph studies to illuminate complex age-old dilemma

By Reginald Smart

N the 2,000 years during which convulsive states have been dis- ssed, a variety of opinions has en advanced about their cause, eatment, and relationship if any alcoholism. Unanimity seems to have prevailed on only one point, namely the harmful effects of alcohol consumption on the individual subject to seizures.

More recent investigations have thrown new light on such questions

as: Are dispomania* and epilepsy related? Can epilepsy be directly caused by alcoholism? Can alcoholism precipitate latent epilepsy? Does the consumption of alcohol increase the frequency and severity of seizures in drinking epileptics? Are epileptics more likely to become alcoholics if they drink?

Non-Epileptics

Epilepsy has been regarded as a disturbance in the "electro-chemical activity of the discharging cells of the brain" (2 p 254). An important question, then, is whether chronic excessive use of alcohol can cause metabolic disturbances resulting in seizures in non-epileptic drinkers. A number of research workers at the Addiction Research Center, Lexington, Ky., attempted to answer this question in "An experimental study of the etiology of rum-fits and delirium tremens" (5). In this study ten former morphine addicts were given large doses of alcohol (266-489 m.l.) under protected conditions, for periods varying from 16-87 days. Four patients who withdrew after 34 days did not experience seizures. However, two of the six patients who remained on the schedule for 48 consecutive days experienced, after sudden withdrawal of alcohol, epileptiform seizures characterized by epileptoid EEG patterns (6). One patient had D.T.'s but three patients escaped both D.T.'s and seizures. Neither the convulsions nor the delirium tremens occurred beyond the two—four day withdrawal period and no residual effects were found in any patient three months after the end of the experiment. Diethelm (7) has estimated that 4.3% of all alcoholics have experienced similar "rum-fits" during withdrawal states. It seems, then, that chronic excessive consumption of alcohol can cause metabolic disturbances sufficient to induce seizures in drinkers not previously thought or known to be epileptic.

Latent Epileptics

It has been estimated (2 p 256) that ten—fifteen per cent of the general population have epileptoid EEG abnormalities; however, only .5% of the population experience seizures (4). Noyes (2 p 256) writes that "such persons (with epileptoid EEG abnormalities) are *predisposed to epilepsy* although the disturbance in cortical electrodynamics is not so serious as to result in seizures, unless the cerebrum suffers some pathological alteration." (2). An important question then, is whether the consumption of alcohol might precipitate seizures in these persons "predisposed to epilepsy" (latent epileptics). Most EEG studies concerning the effect of alcoholic consumption on latent epilepsy (7, 8) deal only with patients who are already addicted. Without a "before and

**Dipsomania is defined as an intermittent thirst, at regular intervals for alcoholic beverages in great quantities (3).*

fter" comparison of EEG patterns e are unable to say whether any normal pattern existed before xcessive drinking began; hence we e unable to distinguish cases of latent epilepsy" from those of the m-fit variety.

Brookside Experience

Several studies have indeed indited that excessive alcoholic conmption can produce EEG abnoralities characteristic of epileptic tterns (6, 9). An analysis of 335 files of Brookside Clinic for e years 1951-4 brought to light least two patients, with manifest izure states after long standing diction to alcohol, who were disvered to have had epileptoid dysythmias without seizures prior to is addiction to alcoholic drinking. lthough these cases seem to indite that latent epilepsy can be ade manifest by excessive conmption of alcohol it is possible at the seizures were induced by nreported trauma. Such traumata uld have caused "pathological alrations" which according to oyes can precipitate seizures in tent epileptics. More research is dicated before a definite statent concerning the effects of alhol on epilepsy can be made.

Although little is known about e relation of alcohol and latent ilepsy, medical opinion, accordg to Lennox (1 p 1) seems to in agreement about the detrintal effects of alcohol on existg seizure states. Lennox found, in his survey of alcoholic clinic patients (1), that over 70% of epileptics were abstainers as against 30% in the general population. He concluded that "most epileptics are under medical care and have been warned against alcohol indulgence" (1 p 8). He states, on the basis of clinical experience, that "petit mal and psychomotor seizures are made more frequent by even small amounts of alcohol." In addition, his survey, based on a 60% response to a questionnaire shows that one in five epileptics experienced grand mal seizures soon after drinking. Persons whose epilepsy resulted from cerebral trauma (secondary epilepsy) seemed more susceptible to the effects of alcohol than those whose condition had existed from birth (idiopathic epilepsy). Amongst secondary epileptics 20% "sometimes" and 7% "frequently" experienced seizures after drinking while amongst idiopathic epileptics 15% "sometimes" and 5% "frequently" experienced grand mal seizures after drinking.

It is possible, however, that the seizures following drinking were due, in part, to the neglect of anticonvulsant medications during drinking sprees.

Epileptics

The last question to be reviewed is the susceptibility of drinking epileptics to alcoholism. A thorough search of the literature reveals little data on the incidence of epilepsy among alcoholic populations. Of

1,335 Brookside patients (1951-4) for whom medical data were available 25 were diagnosed as epileptics. This statistic gives a prevalence rate of epilepsy among alcoholics of 1:53. The prevalence of epilepsy in the general population has been estimated to be about 1 in 200. Hence the epileptic may be more susceptible to alcoholism than the non-epileptic; alternately, however, alcoholics with epilepsy may be more likely to seek treatment than those without epilepsy. No statistics are available for the prevalence of alcoholism among epileptics, so that the relation between the two diseases remains unclear.

This attempt to evaluate the evidence for the relation between alcohol and epilepsy has suggested a number of pertinent conclusions. It seems likely that epileptic states are affected unfavourably by alcoholic consumption; that excessive consumption of alcohol can precipitate epileptoid seizures in withdrawal states; and that epileptics are more susceptible to alcoholism. However, there is insufficient evidence to support the contentions that alcoholism can precipitate latent epilepsy; that alcoholism can "cause" epilepsy, or that epileptics are more susceptible to alcoholism than non-epileptics.

Before-After Studies

Subsequent research bearing on the last two questions would add considerably to our knowledge of the relations between alcohol and epilepsy. In order to assess the effect of long-term drinking on "latent epileptics" it would be necessary to study the prevalence rate of alcoholism among persons whose epileptic EEG's were established before the start of alcoholic drinking patterns. An attempt to answer the contention that alcoholism can cause epilepsy would involve the study of an alcoholic population whose EEG's were known to be abnormal before alcoholic drinking patterns had been established.

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lcoholism

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This periodical is published five times a year in the interests of a deeper understanding of the widespread disorder alcoholism.

Each issue contains pertinent, factual information selected primarily because of its interest to those who are called upon to deal with alcoholism professionally. Articles published do not necessarily represent the views of the Foundation.

If you would like to receive this publication regularly, or if you wish additional information about some aspect of alcoholism, you are invited to write to the Alcoholism Research Foundation, 9 Bedford Road, Toronto 5, Ontario.

There are also branch offices at:

1 Duke St., Hamilton
Institute of Psychotherapy, Kingston
481 Queens Ave., London
1206 Bank St., Ottawa.

Circulation of this issue:

ol. 5, No. 2
ay, 1958

alcoholism

RESEARCH

TREATMENT

EDUCATION

Discuss Nature of Yugoslav Alcoholism

Distinctive view of causes and treatment outlined by Head of Alcoholics' Section Zagreb Institute for Mental Hygiene

*By Josip Dojc, M.D.**

THE Section for the Treatment and Care of Alcoholics of the Municipal Institute for Mental Hygiene at Zagreb, the capital of Croatia, one of the Yugoslav republics, has been treating alcoholics as an out-patient clinic since 1950. In the past eight years nearly

Dr. Josip Dojc, psychiatrist, is Chief of the Section for Treatment and Care of Alcoholics, Institute for Mental Hygiene, Zagreb, Yugoslavia. ALCOHOLISM is pleased to receive this interesting contribution from such an experienced practitioner and scholar in one of Europe's chief wine-growing countries. As was noted in an article in the February issue, alcoholism is understood differently in different countries. It should be noted therefore that such words as "alcoholism" and "social drinkers" as used in Dr. Dojc's article here may carry slightly different meanings from those more usual in North American discussion.—Ed.

12,000 alcoholics appeared for treatment.

Wine Growing Country

Yugoslavia is a wine and fruit growing country, and therefore has considerable production of alcohol, both at home and in factories. For this reason alcoholism is a sizeable national problem, mainly because most of the small farmers grow their own grapes and plums and make their own wine and plum brandy which, as a rule, they consume at home. Predominantly in rural districts people are still convinced that alcohol is nourishing and gives strength. In this way children get acustomed to alcohol. As in other wine-growing countries, alcoholism in Yugoslavia often has a different motive and origin than elsewhere.

For every alcoholic appearing for the first time at our Institute, a special questionnaire is filled in, the questions have a demographical, medical, phsychological, social and economic character. The statistical data thus received from many thousands of alcoholics treated in our Institution during the last eight years tell a great deal about th nature of alcoholism in Yugoslavia

One of the questions on th Institute's questionnaire is "Wh did you start drinking?"[1] On thi question 35.9% of the male an 26% of the female alcoholics de clared that they started drinkin only under the influence of com pany and surroundings.[2] A furthe 21.8% of males treated said the became alcoholics on account o getting accustomed to it graduall in their families. A total therefor of 57.7% of the male alcoholics i our Institution—that is the majorit of our male alcoholics—are "socia drinkers" who began to drin under external influence of societ and company, and surroundings o family.

Examples

The following two cases help t illustrate the idea of infectious ba influence by example of compan and surroundings. There were tw young Germans who came t Yugoslavia after the war becaus at that time they could not get job in Germany. They had live in parts of Germany where peopl

(1) It should be kept in mind that a strict distinction must be made between reasons wh a person starts drinking and reasons why he or she continue to do so. In the latte case an important role is played by habit, remorse on account of drinking and neurosis which often develops.

(2) Almost the same data as in our Institution resulted from an inquiry concernin alcoholics treated at the University Out-Patient clinic in Ljubljana (Slovenia). 32 of the alcoholics treated in that clinic declared that the reason why they began drink was the influence of their companions. At the Red Cross Dispensary in Be grade (Serbia) 43% of the patients stated that the influence of company was th only reason for their beginning to drink. Also among the people treated in th dispensary at Tuzla (Bosnia) 69% blamed the influence of society, company an popular customs for their habit.

id not drink alcohol as a rule. So ney drank only occasionally some eer and always in company. They ever drank by themselves. In their milies there were no alcoholics or ental disorders and they, themlves, showed no such symptoms.

One of them came to a quite olated place 30 km. from the earest town where he worked as n electrician. Within three years e became a heavy drunkard, drinkng at least one litre of plum andy which is the common drink ere. Occasionally he drank even ore, but always in company, never himself. He declared "I had to t used to drinking even this rrible plum brandy which, at the ginning, was disgusting and wful to me and simply burned my roat. I was forced to do so beuse there was no other alternative r me: either to sit quite alone in y little room after working hours, go in the inn where all the other orkers sat together drinking every ening and join them. In this ay I got accustomed to this awful irit and finally became a drunkd who now could not live any ore without plum brandy".

The other German came to a ine growing district where he adually became accustomed to inking wine—also in company ly—which he sought to escape om his loneliness as he was far ay from his country. Today he inks 3 litres or more of wine ery day, but always in company, ver by himself.

Youth Similar

Similar results were obtained in an inquiry made among youth in this country, i.e. among young peasants, young workers and the pupils of an industrial and a high school; 55.3% said they began to drink and were drinking in order to please company or because they were persuaded by their companions. 50.7% of the youths polled stated definitely that they drank alcohol in company only. Also in answer to another question in our questionnaire "Do you drink alone or in company ordinarily?" 60.7% of the male alcoholics treated in our Institution said "In company only". A considerable number of them stressed especially that they never drank alone or desired alcohol except when persuaded or seduced by others. Such statements were confirmed also by their relatives. The matter here clearly is exogenic alcoholism, exogenic alcoholics being "alcoholics who are made not born" as it is put by Dr. Hooton of Washington.

Contrasting Views

Dr. Roche from Geneva quotes in his statistics that 56.4% of the alcoholics examined in his clinic were exogenic alcoholics too. The reason for their alcoholism was bad example, unfavourable society and company or influence of their profession. Roche comes therefore to the conclusion: "In England and in America they consider as the most important reason for alcoholism the

constitutional predisposition which may bring about a passion for poisons. Of course from time to time I see cases in my clinic too, where we can consider the hereditary psychopatic predisposition as the factor for the passion for poisons. But I believe such cases are very rare in an internal clinic. Therefore it seems to me that by far the most frequent alcoholism results from custom".

Dr. Feldmann from Geneva declares that in 46.5% of the alcoholics he examined, he found psychic disorders, while 53% were mentally totally healthy before they began drinking.

While in Yugoslavia, as in many other wine-growing countries, a very great number of alcoholics are "social drinkers" whose alcoholism is of exogenic origin, American authors declare that feeling of anxiety plays an important part in alcoholism; that alcoholics are trying to relieve and to forget that anxiety through alcohol. In our Yugoslav institution only 10.8 of men and 4% of women declared that the feeling of anxiety was the reason that they started to drink. Just as with the psychopathics disposition this reason comes up much less among our alcoholics.

Dr. Barjot from Paris affirms the same with regard to wine-growing France. He says "It is a fundamental mistake to attribute French alcoholism to psychopathic mental condition or to misery". Amon our alcoholics "bad economic posi tion" was declared by only 1.2% of the male and 4.6% of th female alcoholics as the reaso that they began to drink.

At the International Congress i Paris in 1952, Professor Perri argued against seeking causes c general alcoholism among th French people in any special mer tal disposition or in internal cor flicts and difficulties. "A psychi trist" he pointed out "has oppo tunity to examine a drunkard on in the state when he already pr sents disorder in his behaviour. country practitioner, on the oth hand, had seen him while he w still young, normal and balance at least as normal and balanced any average person. He knov which prejudices led him to drin as other young men, because h was compelled both to accept ar offer alcohol at any time lest he considered impolite. From year year he could observe how h character was changing, his intel gence narrowing, until he had b come a miserable creature, such the remnant as the psychiatrist se him".

"After all" Perrin conclud how could it be declared witho absurdity that in France a count where 70 to 80% adults indic alcoholic manners, they had all i dicated some mental disturbar from the beginning".

The difference between "social rinkers" of these countries and ne endogenic alcoholics appeared .g. on the occasion of a theater erformance in our town of the age-play of the American play- right, Tennessee Williams "Cat n Hot Tin Roof". A principal haracter in the play is a young an drinking continuously. He ys himself that by drinking he ies to bring out the liberating oment when he forgets his oubles, conflicts and internal ten- ons. Some of our alcoholics eing the play observed with sur- rise: "To-night we became aware or the first time what a real coholic is. That man drinks be- use of his troubles, but we drink or pleasure!"

Sexes Different

Furthermore, there is as con- rmed by the statistics of our Insti- tion a quite clear difference be- veen our male and female alco- olics with regard to their reasons or drinking. The majority of male alcoholics took the alcohol om internal psychic motives only, hile the proportion between exo- enic and endogenic male alco- olics examined in our institution, mounts to about 35% endogenic.

This fact is important also with gard to therapy and its effect. Dr. arjot from Paris emphasizes that e French alcoholism is first of all alcoholism of custom and above l of the facility with which people can acquire alcoholic drinks. These facts make it possible—as he says —not to consider alcoholism in France as an irrevocable fatalism.

The same also applies to most of Yugoslav alcoholics, and to the preventative and therapeutic conclusions we have to draw from it.

Treatment

In treating exogenic alcoholism (occurring under the influence of company and surroundings or of profession) therapy with drugs— especially with Disulfiram-Antabus —gives very satisfactory results. It is well known that, with regard to endogenic alcoholics, the results of any treatment are uncertain and doubtful "Among neurotic alcoholics we could obtain even temporarily longer therapeutical effects only with intensive psychotherapy, either individual or collective" says Dr. Wörner from Germany.

It goes without saying that the therapeutic prospects and results are often unfavourable in psychopathic and psychotic persons, taking into account that in these cases alcoholism represents only a symptomatic expression of the pathological psychic state.

Dr. Curtis-Prout from New York points to the usefulness of linking "Antabus-support" with psychotherapy, especially in the beginning for interruption of the "cycle of drinking". As far as our

Institution is concerned we could also obtain good results in many thousands of alcoholics with the drug therapy, especially with Disulfiram-Antabus support in connection with psychotherapeutic influence and treatment. We consider therapy successful only when the alcoholic remains completely abstinent at least one year, and when this fact can be verified.

The Out-Patient clinic in Ljubljana obtains especially good results. 63% of about 1,000 alcoholics treated there do not drink alcohol for 2½ years, and are coming regularly for supervision and consultation. Also 62% of 590 alcoholics treated in the Red Cross Dispensary in Belgrade showed a good result. In the Tuzla Dispensary 62% of the alcoholics have been abstaining from any alcohol for the last two years. Among our patients there are many who have stopped drinking for two, three or even four or more years.

Relapse But Return

We confess frankly that a considerable number of people treated in our Institution interrupted the treatment after a shorter or longer period and began to drink anew. But most of them return quite spontaneously after some period of drinking and ask for a new treatment. In a sober interval, repenting and in despair, they remember the happy days when they were able to resist temptation successfully. Therefore the "prodigal son" spontaneously comes back some months, a year, even several years after a relapse. He, himself, asks for help without any kind of compulsion from outside. That is a further advantage of our treatment, and we have proved it many hundreds of times in our daily practice.

"Rebirth"

The treatment is often interrupted because many of the alcoholics treated feel enthusiastic about the initial success and become too optimistic about being cured for life. Much more frequently they break off the treatment and start drinking again under pressure of company and surroundings: 78% of the alcoholics treated in our Institution, who began to drink during or after the treatment, did so only under the pressure of their former company endeavouring by all means to persuade, or even to force, the treated person to drink again. To secure for such patients a more favourable milieu we founded a union of former alcoholics, successfully treated, which is very much like "Alcoholics Anonymous". Our union is called "Rebirth". This very significant name was chosen by themselves. It is pleasant to report that this society has proved very active.

Use Social Workers

In conclusion it must also be mentioned that we do not forget

uring our treatment to take into onsideration the total personality f the drinker, his personal family nd social situation etc. During the reatment we endeavour to find a olution of the drinker's personal, onjugal, family, social and other ifficulties and conflicts. Treatment hich aspires to change and renew he alcoholic's personality by help f psychotherapy demands above ll the alcoholic's social rehabilita- ion. Treatment will prove success- ul and lasting only if we solve the ocial problems and difficulties of he alcoholic at the same time. Therefore our social-medical supervision is very important. We send our social workers, and especially trained nurses, into the homes of the drinkers to find out about their families and social environment, and to check the result of our treatment. Psychotherapy treatment with drugs, personal and social rehabilitation, social-medical supervision, as well as the incorporation in a special union of former alcoholics, in addition to special preventive measures—these are the methods we use in trying to help the mass of alcoholics asking for treatment day in, day out—of course quite voluntarily.

Is Alcoholism a Medical Illness?

*Question and Answer From A.M.A. Journal**

To the Editor: — *I have read much on the acceptance of alcoholism as a disease but have always felt that this is a moral or social problem rather than a medical one. I also feel that cirrhosis of the liver and psychosis would more likely have nutritional deficiency bases. Could you tell me what the grounds are for considering alcoholism as a medical illness?*

M.D., New York.

Answer—A disease is defined as follows: In general, any deviation from a state of health; an illness or sickness; more specifically, a definite marked process having a characteristic train of symptoms. It may affect the whole body or any of its parts, and its etiology, pathology, and prognosis may be known or unknown.

A disease can also be classified according as to whether it is of primary or secondary origin. All patients suffering from the disease process known as alcoholism are also known as problem drinkers. The term "problem drinker" has more of a moral and social implication and exemplifies that type of reasoning. However,

*Reproduced by permission from the Journal of the American Medical Associatoin, May 25, 1957, Queries and Minor Notes section.

alcoholism does denote a condition in which there is a deviation from a state of health. Alcoholism can be classified in to (1) primary alcoholism which includes (a) those patients who from the very first drink of an alcoholic beverage are unable to control their desire for it and (b) those who through use over a great many years have developed an inability to take a drink or leave it alone and have become like group (a), and (2) secondary alcoholism, which includes those who use alcohol for its sedative action as a means of escape from reality and, in particular, from their personal problems, which are usually on a psychosomatic basis. This secondary group comprises by far the majority of patients suffering from alcoholism; however, most alcoholic patients prefer to be in the primary group.

Regardless of which group an individual belongs to when under the influence of alcohol he is ill. The member of the primary group is not ill between episodes of drinking, but neither is an allergic person, unless exposed to the allergy. This does not necesarily imply that primary alcoholism is an allergy; it may be more akin to the excitement that certain drugs may produce (such as barbiturates and morphine) in some patients, since the action of alcohol is similar to sedatives and volatile anesthetics, such as ether.

However, the controversy as to whether alcoholism is or is not a disease is related to the voluntary aspects of the condition in a manner similar to narcotic addictions. Anyone can become addicted to narcotics or alcohol if he uses enough each day and for a long enough period. Both addictions are characterized by withdrawal symptoms, and the withdrawal symptoms can be prevented in both cases by substitute sedative therapy.

In chronic narcotic use, it has been shown (Science 124:263 [Aug. 10] 1956) that continuous use of narcotic drugs inactivates the demethylating enzymes; although no similar mechanism has been shown for alcohol, some such altered physiological state might exist.

Simply because there is a moral and social aspect to this disease does not give physicians the right to deny its existence as a disease any more than they would be able to deny the existence of venereal disease, which is usually quite obvious. As to whether alcoholism is a moral or social problem, rather than a medical one, all that can be said is that is purely a matter of opinion and feeling, and undoubtedly both approaches are of value. The complications of alcoholism are undoubtedly nutritional, since the withdrawal syndrome (delirium tremens) can occur even if the diet and vitamin intake is more than adequate.

ACTIVITY
A.R.F.
NEWS

MAY 1958

DR. E. M. JELLINEK TO STUDY IN CANADA

The world's foremost scientific authority on alcoholism, Dr. E. M. Jellinek, is being brought to Canada next fall by the Alcoholism Research Foundation of Ontario and the Alcoholism Foundation of Alberta to continue his studies. He will be an Associate in the Department of Psychiatry, University of Toronto, and will be guaranteed complete freedom to carry on his work without any consulting or lecturing responsibilities.

Since his retirement over a year ago from The World Health Organization, Dr. Jellinek has been in the United States planning a two-year world wide survey of progress in alcoholism control. The Alberta and Ontario Foundations are now enabling him to spend the greater part of the next two years writing and recording some of his extensive knowledge gained through nearly a quarter century of research on alcohol problems.

Dr. Jellinek was co-founder, with Dr. H. W. Haggard, of both the Yale Quarterly Journal Studies on Alcohol (1940) and the Yale Center of Alcohol Studies (1943), and was from 1941 to 1952 Associate Professor of Aplied Physiology at Yale. He went then to the World Health Organization in Geneva, Switzerland, where he created the International Institute for Research on Problems of Alcohol. He has written numerous scientific articles. mostly on alcohol problems, and is the originator of important research methods such as the 'Jellinek Ques-

tionnaires' and also of the 'Jellinek Formula' which uses certain vital statistics to determine the prevalence of alcoholism in any area.

The first two North American clinics for the diagnosis and treatment of alcoholics were founded by Dr. Jellinek in Hartford and New Haven, Connecticut, and the modern concept of controlling alcoholism by a three-phase program of education, rehabilation and research is regarded as a direct outcome of his work.

APPOINT HAMILTON MEDICAL ADVISOR

Dr. J. W. Tice, prominent Hamilton physician who during the last war headed the R.C.A.F. medical services, has been appointed Chairman of the Medical Advisory Board of the Hamilton Branch of the Alcoholism Research Foundation. It is planned that Dr. Tice will also serve as a Hamilton representative on the Ontario Medical Advisory Board of the Foundation.

A.R.F. EXCHANGES STAFF WITH FINLAND

Robert E. Popham, Research Associate with the Alcoholism Research Foundation for the past four years, is leaving shortly to spend 6 months in Finland where he will conduct research into the prevalence of alcoholism in that country. His stay there will provide opportunities for acquaintance with the work of one of the most advanced alcohol research foundations in the world and will at the same time enable further testing of the Jellinek alcoholism estimation formula. On Mr. Popham's return to Canada a Finnish research worker, Esko Koura, will spend a similar period working with the A.R.F. in Canada.

STAFF PROMOTIONS AND APPOINTMENTS

Robert E. Popham has been appointed to be Assistant Research Director. He is also in charge of anthropological and sociological studies. R. J. Gibbins, Research Associate has been placed in charge of psychological studies. Wolfgang Schmidt, Senior Research Assistant has been appointed Research Associate in charge of research in the area of social work and other applied studies.

MAKE GRANT TO SUDBURY RESEARCH PROJECT

For the first time a research project in a hospital not directly affiliated with a University as a teaching hospital has received a grant from the Alcoholism Research Foundation. $2,500 has been made available to Dr. Thomas P. Dixon of the Psychiatric Department of Sudbury General Hospital to cover expenses of continuing his research into metabolic aspects of alcoholic psychosis.

Together with Dr. Matthew Lynch and Dr. Stanley Raphael of the hospital's Pathology Department, Dr. Dixon is investigating the incidence and nature of fat embolism in the tissues and sputum of patients suffering from complications of alcoholism, such as delirium tremens (D.Ts). (Embolism involves movement of fat or other particles in the blood stream with possible resulting blockage of circulation to vital areas).

PATIENTS' GROUP GIVES TV SET

The Brookside Social Club, a group of out-patients of Brookside Clinic and their families and friends, has presented to the Alcoholism Research Foundation a television set for the clinic's main lounge. Over a period of months the group had subscribed money toward this end with a view to providing something that would help in-patients.

The club takes part every Wednesday evening in some form of educational program provided at Brookside by the Foundation. The programs are arranged by Miss Helen Marshall, a member of the clinic's social work staff, with an active committee which has been formed among the club's members. The committee also takes responsibility not only for projects like the TV fund but also for one of the Wednesday evenings each month, usually a social event involving 60 to 70 people.

HONOURS, AWARDS AND PUBLICATIONS

Miss Muriel Vogel, a senior research assistant with the Alcoholism Research Foundation, recently received three substantial awards—from the Canada Council ($2,000), the University of Toronto ($1,300) and the National Research Council ($1,200). She plans to use these awards to continue her Ph.D. studies in psychology. Miss Vogel intends at present to maintain a part-time connection with A.R.F. during her studies, and on their completion to return to the Foundation staff full time.

The Annual Yale Summer School on Alcohol Problems will have six students attending on A.R.F. scholarships this year. The scholarships provide tuition, board and lodging for the following:—Daniel B. Fenny, Managing Director, Sudbury Children's Aid Society; James Milord, Indian Affairs Branch, Government of Canada; John E. Spriggs, Wentworth County Probation Officer; Miss Gertraut Kullnus, R.N., Alcoholism Research Foundation; John Neilson, Executive Secretary, Ottawa Branch, A.R.F.; Gordon Patrick Evecutive Secretary, Hamilton Branch, A.R.F.

THE ALCOHOL LANGUAGE (Brookside Monograph No. 2) by Mark Kellar, Managing Editor, Quarterly Journal of Studies on Alcohol, and John R. Seeley, Director of Research, Alcoholism Research Foundation of Ontario, is being published (32 pages $1.50) by University of Toronto Press and will be off the press shortly. This is a scholarly discussion of the problem of developing some uniform and effective terminology for those who work in alcohol-related fields. Chapters I and III represent the views of Kellar and Seeley respectively on the problem involved, and Chapter II is a preliminary lexicon by Kellar.

U.S. Protestants Seek Common Ground

Council of Churches Agrees on Statement of Principles*

THE National Council of the Churches of Christ in the U.S.A. believes that the use of alcoholic beverages is a serious threat to the health, happiness, and welfare of many people and to the stability of families and communities. Although differences of conscientious conviction in relation to certain aspects of the alcohol problem exist among the churches of the National Council, the area of agreement is sufficiently large and significant and the problems so urgent as to demand the attention of the Council.

The churches share the belief that all men are creatures of God, accountable to Him for their conduct in all aspects of daily living. Created equal in the sight of God, they are one in their sinfulness, their need, and their dependence upon Him for forgiveness, restoration and renewal. God freely offers this grace through Jesus Christ and the power of the Holy Spirit who brings men to faith in Him. All Christian ethical decisions are ultimately grounded in this redemptive and restorative deed of God in Christ. Faith, the reenactment of that deed in our lives, is the ground of meaningful existence, genuine community, individual fulfillment and the source of courage to live in the world.

On Ministry to Victims of Alcoholism

The churches share a pastoral concern for alcoholics, problem drinkers and their families. We recognize that once drinking has passed a certain point it becomes alcoholism, an affliction which cannot be met effectively by the unaided efforts of the victims.

Alcoholics are persons in need of d i a g n o s i s, understanding, guidance and treatment. They are especially in need of pastoral care and the divine love which the

**In view of the wide diversity of views held on alcohol problems by members of different religious denominations this American effort to find common ground should be of interest in Canada. It has been passed by the General Board of the National Council of Churches of Christ in the U.S.A. after being prepared by the council's Joint Committee on Problems of Alcohol. The Committee's members were: Dr. Harold C. Letts, chairman; The Rev. H. Rushton Bell; Miss Miriam Corbett; Miss Alts E. Dines; Dr. Clifford J. Earle; Dr. Caradine R. Hooton; Mr. John Park Lee; Rev. James Renz; Dr. R. H. Edwin Espy; The Rev. Howard G. Schade; Dr. Francis A. Shearer; Rev. Mark Shedron; Miss Esther C. Stamatz; Miss Thelma Stevens; Dr. William J. Willaume; Rev. M. Moran Weston; Dr. Lauris Whitman Rev. David A. Works.*

church can bring them. There need be no condoning of their behaviour, but neither should a church permit its antagonism to alcohol to prevent its offering an effective ministry to alcoholics and their families. Ministers and churches should not be content merely to direct alcoholics to treatment centres.

The concern of the churches for alcoholics and their families is being shared increasingly by the community as a whole. We look to the member churches of the National Council to encourage the establishment and maintenance of clinics and other appropriate therapeutic facilities, when completely conducted, for the victims of alcoholism. We urge the churches to give any help possible especially to those organizations which seek to include the resources of the Christion faith in working toward the cure and rehabilitation of alcoholics.

The churches should disseminate such sound information as is now available on the understanding and counselling of persons with alcohol problems. The churches have a special responsibility to assist pastors to become more effective counsellors in this field. They also should encourage and undertake new work looking toward the more effective use of the resources of the Christian faith to reclaim problem drinkers and alcoholics.

We recognize the complete origins of alcoholism and excessive drinking in social pressures, emotional instability, bodily functioning and the nature of alcohol itself. We accept the fact that alcoholism is an affliction which requires treatment. We assert our conviction that the ethical aspects of the use of alcoholic beverages should be of deep concern to the churches and the community as they seek to help the victims of alcoholism.

On Alcohol Education in the Churches

Alcohol education in the churches should cover all aspects of the use of alcohol drinking, drunkeness and alcoholism — and should be conceived in long-range terms.

It should reach adults as well as children and youth. Each individual should be helped to an understanding of the problems arising from alcoholism, and an appreciation of the church's role as a redemptive fellowship in the lives of alcoholics and their families. Accurate, scientific and factual material, intelligently graded and presented, should be the basis for the churches' programs of education and action.

The aim of alcohol education is conviction and decision based on accurate knowledge and Christian ethical standards. It should clarify and explain the nature and strength of the pressures toward drinking and aid in the develop-

ment of mentally and spiritually healthy people who can recognize, evaluate, and accept or reject pressures rationally and ethically as mature persons. It is more effective to win understanding than to coerce people. Alcohol education while an object of special attention in some of the churches, is closely related to other programs of ethical and social concern.

On Alcohol Education for the Public

While the chief educational task of the churches is with their own constituency, there is also a Christian social responsibility for guidance of the general public.

The churches should encourage relevant public and private agencies to include in their work the dissemination of scientific and accurate information about alcoholic beverages. This relates especially to the public schools, public health departments and certain other public agencies. In their programs of alcohol education for the public, we urge the churches to cooperate with other groups, public or private, provided their basic convictions are not compromised in the process of cooperation.

On Social Control of Alcoholic Beverages

1. We have affirmed our belief in the vigorous program of continuing education based on the findings of theological and scientific research as the necessary means for developing attitudes toward and making decisions on the use of alcohol. If this education is to be effective as a social control, it must be motivated by moral concern, to which all religious groups in America can and should make their contribution.

The ethical concern of the Christian churches is an outgrowth of the transforming power of the gospel itself. Where men's whole lives are changed through the permeation of the gospel, there will be resulting change in all aspects of their living, including the use of alcohol. It is the conviction of the Christian churches that widespread acceptance of Christian ethical standards provides the most effective means of social control.

2. We recognize that the alcohol problem is related to other social problems. Thus another means of social control involves the removal of degrading social conditions such as poverty, disease, bad housing, poor education, and inadequate recreational and health facilities. Effective social control involves providing mental health clinics, family case work agencies, and pastoral counselling programs as a means of strengthening persons emotionally and socially. Here again the healing, renewing power of the Christian faith must play its true role. Here also the whole social welfare program of the churches makes its

contribution.

3. The churches' efforts, properly directed to the achievement of adequate programs of education, Christian teaching, and social renewal, will make more effective whatever legal controls may be necessary. The general public must be protected from those whose drinking endangers others. The legal controls relating to beverage alcohol should be aimed to reduce its excessive use.

Many kinds of legal controls have been advocated by member churches, among which are the regulations of advertising of alcoholic beverages, local option, government production and sale, the use of public revenue from the sale of alcoholic beverages for the benefit of alcoholics and their families, and the limitation of places and hours of sale. There is wide agreement among the churches with regard to legal restraints on driving while under the influence of alcohol, and on the sale of alcoholic beverages to minors.

Conclusion

The serious and complicated problems arising out of the use of beverage alcohol cannot be ignored. Christians should examine their own conduct in relation to alcohol. Our churches should be sure youth and adults are informed about the nature of alcohol and the problems connected with its use. They should do all in their power to strengthen their ministry to alcoholics and their families. Long range programs involving research, education, Christian teaching and social action should be developed and carried through responsibility by the churches.

Explain Alcohol's Effect on Colds

Alcoholic beverages are helpful in fighting the common cold — at least in the early stages.

This was reported by Dr. Noah D. Fabricant, Chicago otolaryngologist, in the current (March) Archives of Otolaryngology, published by the American Medical Association.

Dr. Fabricant said, "Although consumption of alcohol is obviously not a cure for the common cold, its beneficial role in some persons can neither be minimized nor dismissed."

Alcohol has long been a popular remedy for warding off colds after chilling or exposure in in-

clement weather. It increases blood circulation, provides warmth and comfort, induces drowsiness, and promotes a desire to rest.

According to Dr. Fabricant, "Once acted upon, the decision to rest in bed can serve a most useful purpose. Rest in bed diminishes the severity of the common cold, limits spread to others, and reduces the frequency of complications."

But alcohol is valuable in fighting a cold in still another way.

A cold is preceded by a lowering of the temperature in the nasal passages and a constriction of blood vessels within the nose. The passages then become dry and the defense against the cold is weakened. This paves the way for acute infection, the doctor said.

The prime intent on discovering a cold in its early stages is to restore the nasal passage to its normal state. This can best be done by raising the temperature of the membranes.

In the test conducted by Dr. Fabricant, it was found that the nasal temperature could be raised after the consumption of alcohol.

Twelve persons, two with symptoms of a cold, were given one ounce of a blended whiskey. Temperatures were checked before the test began and again at 15 minute intervals following the taking of the alcohol.

All twelve showed a nasal temperature rise within 30 minutes.

According to Dr. Fabricant, the results indicate the physiological usefulness of an alcoholic beverage during the very early stages of the common cold.

List All Research Projects 1951-57

The 1957 annual report of the Alcoholism Research Foundation provides complete cross-classified descriptions of research projects undertaken by the Foundation since its establishment. In the following pages as a convenient reference the titles of all the major studies involved have been listed under four main headings: (A) Alcoholism Treatment, (B) Alcoholism Description, (C) Alcohol Use and (D) Instrumental (methodological) Studies. Enquiries about any particular project should refer to the study number in brackets at the end of the title.

A.R.F. RESEARCH PROJECTS 1951-57

ALCOHOLISM TREATMENT

Completed

The use of lipotropic factors in the treatment of alcoholism (4)

A new drug for alcoholism treatment (9)

A preliminary attempt to investigate the effects of clinical treatment on the behavior of alcoholic patients (17)

Pharmacological studies of disulfiram and related substances (21)

The association between motivation for seeking treatment and treatment outcome in a sample of alcoholic patients (24)

The relation between drinking behavior and social participation before and after treatment in a sample of alcoholic patients (32)

Problems of referring a 'protection client' to an alcoholism treatment centre (39)

Relation between reason for contact and duration of contact with Brookside Clinic (44)

Historical and comparative study of compulsory treatment for alcoholics with particular reference to Ontario (56)

Discontinued

Clinical study: Citrated Calcium carbimide and disulfiram (36)

Continuing

A follow up study of alcoholic patients admitted to Brookside Clinic Treatment facilities (37)

Psychotherapeutic processes with large groups of alcoholic patients (38)

Toxicity of citrated calcium carbimide (49)

Biochemical studies in alcoholism (53)

Relation between drinking behavior and employment (in alcoholic patients) before and after treatment (61)

Relation between drinking behavior and father-child relationship (in alcoholic patients) before and after treatment (62)

Hypnosis (in conjunction with other therapy) in the re-education of alcoholics (65)

ALCOHOLISM DESCRIPTION

Completed

Measuring hostility in alcoholics (8)

Undersocialization in the incarcerated alcohol addict (1)

Chronic alcoholism and alcohol addiction: a survey of current literature (12)

Alcoholism in Ontario: A survey of an Ontario County (13)

Study of a prison aggression group (18)

Factors in the background of the imprisoned chronic inebriate (20)
A critique of the genetotrophic theory of the etiology of alcoholism (26)
A statistical report relating to alcoholism and the use of alcoholic beverages in Canada (27)
Postwar trends in hospital admissions for alcoholism in Canada (28)
Alcoholism and traffic accidents: a preliminary study (29)
The Jellinek alcoholism estimation formula and its application to Canadian data (30)
A survey of the experience and opinions of Ontario clergymen with respect to problems of alcohol and alcoholism (35)

Discontinued

Problem drinking prevalence in a large industry (45)
Alcoholism as viewed by Toronto Children's Aid Society (52)
Social status and mobility patterns of alcoholic patients (57)
Studies of liver disease in relation to alcoholism (71)
Frequency and nature of skin diseases in alcoholics (75)
Alcohol problems among the Metis and Indians of N. Saskatchewan and their theoretical implications (76)

Continuing

Personality factors in alcoholism: an obverse analysis of objective tests of temperament (41)
Effects on the alcoholic syndrome of degree of social acceptance of drinking (46)
Differential substitutive learning capacity in alcoholics, neurotics and 'normals' (54)
An exploratory study of alcoholism among Jews (58)
Traffic accidents and alcoholism: a study of accident histories of alcoholic patients (60)
An exploratory study of population potential and alleged alcoholism rates (68)
Mortality and alcoholism: a study of the life expectancy of the alcoholic in relation to the measurement of the incidence of alcoholism (74)
A comparative analysis of the social characteristics of Brookside patients (77)

(C)—ALCOHOL USE

Completed

Some aspects of Ethanol metabolism (1)
The introduction of alcohol into Iroquois Society (19)
Drinking patterns in an Industrial society (31)
Young adult drinking habits (33)
Low blood alcohol concentration and psychological adjustment as factors in psychometer performance (51)
Some effects of alcohol on the central nervous system (55)

Discontinued

A survey of drinking habits and attitudes in one community (7)
Role of alcohol in metabolic and structural disturbances in the animal (40)

Continuing

Carbohydrate metabolism in the alcohol-fed rat (43)

The urban tavern: An exploratory anthropological study (59)

Vascular and metabolic changes in acute alcohol intoxication (66)

Toxic joint action: Ethanol and selected barbiturates (67)

The effect of personality adjustment and low alcohol concentrates on the performance of a psychomotor task after frustration (69)

A comparative study of the effects of recent changes in Ontario liquor laws as reflected in statistics of drinking, insobriety and alcoholism (12)

A periodic statistical report regarding alcohol use and alcoholism in Canada (78)

(D)—INSTRUMENTAL STUDIES

Completed

The Q-technique as a possible means of differentiating alcoholics from non-alcoholics (2)

Attitudes to drinking alcoholic beverages: an attitude scale (6)

Breath sample container development (48)

Family transmission of drinking patterns and mating behavior: a model (63)

Alcohol and epilepsy: a review of the literature (64)

A scale for the quantitative measurement of acceptance of drinking (73)

Discontinued

Estimation of blood acetaldehyde (50)

Continuing

Search for an emetic drug triggered by a small amount of alcohol (42)

Development and standardisation of a projective test for use in research on alcoholism (47)

Estimation of blood cyanamide (70)

The alcohol language (79)

Nomenclature, conceptualization etc. in the alcohol language (80)

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Each issue contains pertinent, factual information selected primarily because of its interest to those who are called upon to deal with alcoholism professionally. Articles published do not necessarily represent the views of the Foundation.

If you would like to receive this publication regularly, or if you wish additional information about some aspect of alcoholism, you are invited to write to the Alcoholism Research Foundation, 9 Bedford Road, Toronto 5, Ontario.

There are also branch offices at:

1 Duke St., Hamilton
Institute of Psychotherapy, Kingston
481 Queens Ave., London
1206 Bank St., Ottawa.

Circulation of this issue: 10,

Vol. 5, No. 3
September, 1958

alcoholism

RESEARCH

TREATMENT

EDUCATION

Finland Studies Effects of New Outlets

Investigations both before and after introducing sale of beer and wine throw light on resulting changes

*By H. David Archibald**

Alcohol sale policies, the desirable type of legislation, and the effects of alcohol on the Finnish nation have long been a matter of great debate in Finland. On a majority vote of the people, prohibition was discarded. The new policy introduced at the end of prohibition, however, limited the sale of alcoholic beverages to the urban centres. At the same time the government of Finland decided to move into the process of selling alcoholic beverages very, very

**H. David Archibald, Executive Director of the Alcoholism Research Foundation of Ontario has had extensive opportunities to observe first hand the programs related to alcohol use and alcoholism in a number of countries. In this article he summarizes an interesting Finnish investigation which suggests a type of research that could be done in parts of Canada where changes in liquor control were being considered.*

cautiously and stated that very careful evaluation of the effects of various policies must be part of the total responsibility accepted by the alcohol Monopoly Board (equivalent in general function to the Liquor Control Boards of Canada). Consequently, the Alcohol Monopoly Board in Finland is sponsoring intensive research investigations into all aspects of the problems of alcohol in society.

As part of the research investigations in Finland, a large scale research project was conducted in an attempt to evaluate the effects on a community of the opening of a store for the legal sale of beer and wines when no other legal facility had previously been established.

Test Proposals

The occasion for the project arose when a proposal was being considered in the Finnish Parliament to introduce the sale of beer and wines throughout the rural areas of Finland. As rural areas in Finland had been without alcohol stores for half a century, opinions as to what might happen if the proposal were realized seemed to vary widely, depending on whether one was in favour of the proposal or opposed. It was decided that the effects of the proposals could be forecast reliably only through an alcohol policy experiment and through the findings of this experiment. Consequently an experiment on a minor scale of what had been proposed for the entire country was established.

Four Communities

Briefly, the research team headed by Dr. Pekka Kuusi selected four communities in which no legal sale of alcoholic beverages had been established. A systematic study of the drinking habits, the attitudes toward drinking and non-drinking, and many other features pertaining to the life of the residents was begun. When this study was completed, beer and wine stores were introduced into two of the communities. These stores constituted the scientific variable. Following the introduction of the stores, another complete study of the four communities was made to determine the changes that occurred in these communities, and, more particularly, the changes in two communities that could be attributed to the introduction of the beer and wine stores.

Before Change

Many interesting findings were derived from this study; the following are some of the main ones:

First of all there are some general findings applicable to all the communities in the study:

(a) It was evident that the frequency of drinking for both male and female increased with the increasing urban character of the locality. The

proportion of the people who had never used alcohol, however, did not vary with the size of the community, i.e., the proportion of the population who had decided on total abstinence as a way of life was the same in both country and the towns. This proportion remained constant irrespective of the size of the community.

(b) The frequency of drinking was also related to industrialization, that is, the more industrialized the community, the smaller the number of total abstainers. The researchers noted that "This is a material finding. It seems to indicate that the industrialization of rural areas, from the viewpoint of temperance, means a doubled threat. Both the formation of urbanized population centres and the transition into industrial employment. supplementing each other, lessen men's chances of abstaining from alcohol".

(c) Drinking frequency was also related to education, in the sense that the researchers found a positive correlation between drinking frequency and higher education. The higher the educational bracket, the higher the drinking frequency.

(d) In terms of participation in athletics, it was noted that "boys interested in athletics did not differ from other boys as regards their frequency of drinking". With an increasingly active interest in athletics the drinking frequency at least did not seem to diminish.

(e) The relation between churchgoing and the drinking frequency, however, proved quite clear. Among the active churchgoers, the relative number of men who had given up alcohol and who had not taken a drink for a year was significantly higher than one would expect on the basis of the normal distribution.

After Change

Following the introduction of the legal beer and wine stores, these conclusions were reached:

(a) According to researchers, "It was clearly evident that the number of occasions on which alcoholic beverages were consumed increased. No such increase, however, could be ascertained to have taken place among persons who drank liquor rarely, or not at all. In the main, only males who had previously been classified as drinkers increased their consumption.

The researchers reported it this way: "We know that the opening

of beer and wine stores at rural population centres did not reduce the number of temperance persons, including those who have not had a drink for the past year, but we also know that it increased the frequency of drinking among those who were already classified as drinkers".

In other words, those who had made a decision not to drink were not influenced by the increased availability of alcoholic beverages.

(b) Considerable change occurred in the drinking habits of young people. Prior to the establishment of the legal stores, distilled spirits and illicit beverages accounted for 92% of the alcoholic consumption by boys between the ages of 15 and 19, while only 8% of the consumption was made up of mild beverages. Since the opening of the legal stores, the consumption of beer and wine rose to 85% of the total. This represents an almost complete reversal of the drinking pattern.

(c) No difference could be observed in the frequency of drunkenness, in those communities in which the new stores were located, as compared with the communities that remained without a store. The research team concluded that on the basis of this experiment, the existence of the legal stores in these communities did not affect the frequency of drunkenness. They further concluded that drunkenness as a social phenomenon has a far from clear relationship to the alcoholic distribution system that may be in effect in a country.

Need Similar Canadian Test

There are many interesting findings in this and other Finnish research as well as in other projects that have been concluded in other Scandinavian countries. Much that is of basic importance to work in the field of alcohol in Canada can be learned from these countries. However, this particular research was carried out in Finland, and the findings are not necessarily true for the Canadian scene. On the other hand, we must not ignore them solely because Finnish culture and geography are different from ours. This research, and many others conducted by Scandinavian scientists provide very interesting leads for our own research investigations. We should carry out our own research to determine whether or not they apply to the Canadian scene. The most interesting research and certainly the most important facts are those that are true internationally as well as locally. Such is the nature of basic facts.

Communities Can Deal With Alcoholics Only By Teamwork Between Professions

Social worker suggests deliberate sharing of responsibility between doctors, clergy, nurses and others

*By R. Margaret Cork**

Fewer than one in ten out of the 60,000-70,000 persons in Ontario suffering from the illness known as alcoholism are taking advantage of medical treatment facilities or of the program of Alcoholics Anonymous.

Is this because there are too few clinics and A.A. groups? Or because other helping professions may tend to leave the job to so-called specialists in the field? Have such specialists, by encouraging referrals, unwittingly discouraged others from giving effective and needed help to many alcoholics?

Community Approach

My own belief, based on seven years doing treatment work at Brookside clinic and considerable association with the work of A.A., is that the answer lies in developing a more "therapeutic community." By this is meant a climate of understanding and acceptance which can make rehabilitation, and prevention also, much more real. Though there may be much room for improvement or growth in both clinics and A.A. groups, these alone are not likely to catch up with the growth of the problem. Instead there is needed a community approach to alcoholism so that people with real or potential drinking problems may become able to seek professional advice and guidance without too great fear or shame; so that those already ill may be able to seek help before the illness has too seriously affected their total personality or life situation.

This calls for increased concern and acceptance of responsibility by all members of all the human service professions. In turn, these professions can influence the larger lay community. If the different professional groups in a community could deepen their understanding and work together

**Miss R. Margaret Cork is chief Psychiatric Social Worker, Brookside Clinic, Toronto. This article is based on a paper she presented to the Alabama State Conference of Social Work, Birmingham, Alabama, April 1958.*

as never before, we might begin, not only to rehabilitate a greater number of those already ill, but hopefully to discover more effective means of prevention.

This calls for more than just greater knowledge about alcoholism and the alcoholic, more than just a probing of professional skills and resources. Over and beyond these it calls for greater understanding of past failures to rehabilitate the alcoholic, and greater acceptance of the need for all members of such service professions as physicians, clergymen, nurses and social workers to work together as a community team.

Some of The Difficulties

Implicit in any effort to help the alcoholic is the ability to give of self, warmly and without expectation of much in return, as one does to small children; to give without needing to control or to possess; to be able to show a sense of caring no matter what the recipient's behavior, though not necessarily to condone the behavior. There are, however, two or three factors which often inhibit us from doing just this. I refer first of all to our own feelings towards drinking and drunkenness or the use of alcohol in any form. Most of us have remnants of misconceptions, prejudices and attitudes taken on from our parents, friends, or experiences, religious or otherwise. The point is not that we won't have these, but that we recognize them and learn to control them; to work our own way through our fears and conflicts as far as possible, for such feelings can seriously interfere with our attempts to help the alcoholic.

Next in importance is our ability to accept the degree of emotional immaturity seen in most alcoholics either as a result of regression from a previously achieved maturity or of arrested emotional growth. So many of the so-called adults we are trying to help may have the dependency characteristics of the infant, the small child, or the teen-ager (though often hidden by considerable overt independance). Unless we are reasonably secure in our own degree of emotional and professional maturity, we may become threatened, and as a result may react to the alcoholic as indulgent, withholding, controlling, or directing parent figures. We may become conflicted by his inconsistency, his impulsiveness, and his low frustration level. We may become impatient with his inability to do what we know he is mentally capable of doing, or lose sight of his need to be given responsibility s l o w l y. Often we may unconsciously meet our own needs in his dependency, or we may deeply resent his dependency. If we are not aware of the many implications of his dependency, we will be limited in our efforts to help him.

Other factors that limit us in working with alcoholics are: our inability to take the degree of hostility he shows, without hitting back

or withdrawing in fear; our inability to resist being manipulated into a particular role, such as the "saver of the marriage" or the "protector of the job"; our inability not to get caught up in the alcoholic's sense of urgency, his impatience, so that we go faster than we know he can go; our inability to avoid taking on the discouragement and the hopelessness that is often inherent in the sick person, so that we stop trying to help; and last, but not least, our inability to know our own professional limits. The alcoholic, more than almost anyone else, seems to make us feel we can be all things to all people.

Working Together

So much for some of the difficulties in helping alcoholics. What then of the business of working with other professional people? It will take a conscious effort on the part of all service professions to stop feeling threatened by one another; to gain a real appreciation of the p a r t i c u l a r contribution of others; to accept a degree of overlapping in each of our roles; to lose some of our possessiveness and competition to cure the alcoholic; and lastly to free him to relate to each of us, without allowing him to play one against the other. This calls for a conscious effort by each professional to get to know a person in each of the other helping professions in his community. This means getting to know not just an agency or a name but an individual and to know him personally, so that the alcoholic senses our trust and confidence in the person to whom we are referring him. We must not only learn to refer with genuine appreciation and acceptance of the service a particular person can render, but also to do so without giving the alcoholic a sense of rejection. Go with him literaily, or figuratively, as he seeks out a new source of help. Never confer about him or refer without his permission. Last, but not least, stand by and support him in his efforts to understand and use a new helping relationship.

Having looked at some of the factors involved in past failures to help the alcoholic, and at more effective ways of various service professions working together, I would like to touch more specifically on the particular roles I feel each key service profession might play in this whole problem. While the four professions which I have selected (general physicians, clergy, social workers and nurses) may each have a particular role to play, I would suggest that much of what I have to say should have meaning also for teachers, probation officers, personnel workers and all who may be in contact with these troubled people.

The General Physician

I would focus on the general physician first, not because the alcoholic is primarily a physically damaged or physically ill person, but because "the physician in general

practice is the one most likely to see the earliest manifestations of what may eventually develop into the most serious psychiatric disturbances, and he will have the best opportunity of preventing them if he is properly prepared (oriented and sympathetic) for the recognition of the early danger signals."* Long before the alcoholic or his family recognize the deeper, more serious aspects of his illness — or perhaps while he is still only a potential alcoholic — he may seek help from a physician during or following a drinking bout. While many physicians have, since the problem began, successfully treated hundreds of alcoholics, the fact remains that too many are still fearful of, or for other reasons are unable to treat the illness successfully in its early stages. Too many are still treating the symptoms only, and the prescription is a palliative which may switch an alcoholic from drink to drugs. Often the prescription given for on-going treatment is in such words as "Cut the stuff out," with no direction or help in taking the prescription. Rarely is such a prescription taken seriously for any length of time by the patient, even when there is a real threat to life through serious liver damage, ulcers or other physical complications.

The Clergy

Let us turn to a second helping profession — the Clergy. Often the pastor or priest is the last person in the church to know that a parishioner has a drinking problem. The shock and the concern he may feel on hearing about it often gets in the way of his truly helping the alcoholic. Many of his traditional ways of helping people do not work. Traditionally the clergy have seen alcoholism solely as a moral problem and attempted to help the alcoholic by pointing out the wrongness of his behaviour, thus adding to the great burden of guilt he already carried within him.

Today there is a growing awareness of the clergyman's role in rehabilitation and education in the field of alcoholism. Along with this is a recognition on the part of the clergy of their need to bring to their role a new understanding and a new or different use of their traditional skills.

The challenge to the clergy as it seems to me, is not just to learn more about alcoholism but to see the alcoholic as a person whose approach to an understanding or acceptance of God's love is immature, in spite of early attendance at Sunday School or Church; whose guilt and fears, in relation to clergy in particular, are so great that it takes tremendous courage to approach the priest or pastor for help. The alcoholic however comes to his clergyman not just because he wants help with his drinking problem, but often because he wants, like most

**Alcoholism and the General Practitioner, by Jos. Hirsch; Postgraduate Medicine, Vol. 8, No. 1, July 1950.*

of us do, to be a better person or to find a new meaning to life.

Nurses

A third professional service group are the nurses, particularly public health nurses, who have perhaps one of the greatest opportunities to be in contact with the alcoholic and/or his family. Public health nurses have access to all homes where there are school aged children, and thus have a greater chance than most of the other helping professions to know of upset children and disturbed family life due to alcoholism. More often than not the nurse is reluctant to use this opportunity to recognize the illness or to act effectively in getting the alcoholic to treatment. Very often the nurse may give intense counselling to the wife of the alcoholic on all other health problems but fears to counsel "for the sake of peace", or because she is "fearful of interfering", on the major illness in the home.

Not only public health nurses but nurses in medical wards with alcoholic patients admitted with a diagnosis of a liver condition, nurses on psychiatric wards, and nurses on emergency—all have a rare but real opportunity to relate to the sick person at a time when his defences may be down, when he is feeling contrite or humble. Perhaps for the first time in his life he might be given some of the tender nurturing we all need, especially when ill, and through the nurses' interest and acceptance of him as a person, begin to gain some security to talk about his problem or contemplate doing something about it.

Social Workers

The fourth and last professional group I would like to discuss are the social workers, chiefly those in social agencies serving families, young people and children. Traditionally social workers, like other helping professions, have attempt-

ed, without any greater success as a group, to help the alcoholic. Like most of the other professional groups, the social worker has become discouraged, frustrated, and has often taken on a feeling of hopelessness because of past failures. Social workers however, by training should be the best equipped to help the alcoholic use formal treatment services and to work directly on the realistic problems which he has, both as cause and effect of his drinking. They can give leadership in the community as they work in a cross section of it, not only toward better understanding of the alcoholic, but also in their work of stabilizing family living toward the concept of prevention.

Share Responsibility

These then are four of the professional groups who I feel have a significant and actual role to play in treatment and prevention in this field of alcoholism, not just as individuals with particular skills, but especially as members of a community team, sharing and pooling skills and responsibility. Such a team should not only be able to share appropriately and realistically in rehabilitating the alcoholic but each member must assume a responsibility for interpreting the illness and the ill person to others in the community. Few of us perhaps have fully conceived of the tremendous impetus to getting well that the alcoholic might feel if there was more general understanding and acceptance of the illness and of the sick person. What hope there might be for controlling this illness if we had the same public feeling behind our efforts and his, as we do behind programs for the polio victim or the blind!

Professional people have been slow to use their known and tested skills in the field of alcoholism. In spite of the advances made in the last fifteen years or so in studies of this illness, it is increasing at a greater rate than most of us realise. Well-established clinics and A.A. groups working at full speed cannot begin to cope with those already ill. I do not say that community teams per se are the solution to the problems presented by this illness. I do believe, however, that through such an approach larger segments of our communities might more readily change their attitudes and more quickly lose their fears; that within an atmosphere of community acceptance, thousands of alcoholics not yet getting help might find the courage to acknowledge their illness; that above all, the helping professions might begin to lose some of their individual sense of apathy, discouragement, and isolation, might individually revitalize and revamp their time-tried treatment skills, and together with other helping professions find the answers without which we cannot combat one of the most serious illnesses of our time.

Review Decade of Statistical Trends In Ontario Alcoholism and Alcohol Use

If there is any one problem which most fields of public health work have in common it is the securing of adequate statistics covering a fairly long period of time. Alcohol problems have been no exception in this regard, especially since whatever figures are available in the field are subject to such a wide variety of interpretations.

Public attitudes have made it particularly difficult to obtain by direct reporting any consistent measurements of the extent or prevalence of alcoholism. As with tuberculosis or venereal disease, there has been a reluctance to report or even admit the existence of a case of alcoholism, and this tendency has been exaggerated by the fact that, at least until recently, alcoholism was not widely regarded as an illness at all, but rather as a moral shortcoming. Quite apart from this, alcoholism is a progressively deteriorating condition in the individual and it is therefore difficult to define just when it begins for any reporting or statistical purpose, and it has tended to become confused with simple cases of occasional excessive drinking in which addiction or progressive deterioration might not have been involved.

The discovery by Dr. E. M. Jellinek (1) of a definite relationship between reported deaths from cirrhosis of the liver and the number of alcoholics in a population has made it possible to estimate the prevalence of alcoholism in certain countries for limited periods of time. Extensive clinical and post mortem investigations, together with a study of the effect of prohibition periods on certain vital statistics, have enabled Jellinek and others to establish constant values for various countries for such factors as the percentage of liver cirrhosis deaths attributable to alcoholism; the percentage of all alcoholics with complications who die of liver cirrhosis, and the ratio of all alcoholics to alcoholics with complications. By using these factors in the so-called Jellinek formula, estimates of the prevalence of alcoholism have been made in many areas and, with few exceptions, independent field surveys where attempted have produced prevalence figures corresponding very closely to those obtained by the formula.

Best Estimates

This is not to say that the Jellinek method is necessarily the last word for all time in measuring the

(1) *Expert Committee on Mental Health. Report on the First session of the Alcoholism Subcommittee. World Health Organization Technical Report Series No. 42 Geneva, 1951.*

TABLE I

Alcoholism and Alcohol Consumption Statistics
Ontario — 1946-1955

Years	(a) Estimated total number of Alcoholics	(b) Alcoholics per 100,000 population aged 20 and over	(c) Consumption of Beverage alcohol per capita aged 15 and over	(d) Estimated proportion of users of alcohol in adult population
1946	31,820	1,150	1.28 gal.	—
1947	36,360	1,290	1.43 gal.	—
1948	40,120	1,400	1.56 gal.	65%
1949	45,130	1,545	1.58 gal.	66%
1950	48,700	1,635	1.59 gal.	70%
1951	48,830	1,600	1.59 gal.	64%
1952	51,440	1,640	1.61 gal.	69%
1953	56,935	1,780	1.69 gal.	—
1954	60,770	1,860	1.72 gal.	—
1955	63,070	1,900	1.69 gal.	71%

extent of alcoholism; but until any better methods are developed which can be applied at all economically, the Jellinek method does provide a way of making estimates of prevalence, not only in recent years but also for a limited period of past history (2). For some time, therefore, the Alcoholism Research Foundation has been compiling the basic data needed for such estimates and for other historical approaches to alcohol problems for as far back in time as they are available for Canada and its provinces. This means as far back as the first census of Canada in 1871 for some data. For reports of death from liver cirrhosis in a form that can be used to estimate the prevalence of alcoholism it means back to 1901 except in some provinces. It is planned to publish all these compilations, including revisions of more recent estimates already made, by late fall of this year. This will be the first annual volume in a projected continuing series of statistical reports.

Decade Only

The contents of this volume are too vast an amount of data to discuss or review in one issue of ALCOHOLISM. Initially therefore this article will attempt to summarize the rates on alcoholism and related factors for the ten most recent years of the series to be covered in the forthcoming volume. The ten years from 1946 to 1955 inclusive conveniently describe trends in this field during the post-war era, Table I therefore presents

(2) *The Jellinek Alcoholism Estimation Formula and its application to Canadian Data. R. E. Popham M.A., Q.J.A.S. 17:4:559-593.*

for the province of Ontario— (a) the estimated number of alcoholics in each year, (b) the number of alcoholics per 100,000 persons in the population aged 20 years and over, (c) the consumption of beverage alcohol (pure alcohol equivalent) in imperial gallons per capita aged 15 and over and (d) the estimated percentage of non-abstainers in the adult population.

One In Fifty

It will be seen from this table that by 1955[3] the estimated proportion of alcoholics in Ontario's adult population was 1.9%; in round figures, nearly 2% or one in fifty adults. As a proportion of adult drinkers it represents 2.7% or one in 37 adult drinkers.

The growth of this public health problem over this period can be looked at in a number of ways. First the total number of alcoholics in the province has increased in the post-war decade from 31,220 to 63,070, a percentage increase of 98.2%. However if the population increase in the age group affected is taken into account, as is done by calculation of a rate per 100,000 aged 20 and over, the result is an increase in rate from 1,150 to 1,900 or 65.2%. One further refinement might be to consider this rate in relation to the estimated number of actual users of alcoholic beverages instead of in terms of the entire population aged 20 and over. On this basis the increase has been 55.2%.

Number Of Users

The only way in which the percentage of users of alcohol, and of abstainers, can be estimated for the period is from results of a question asked from time to time by the Canadian Institute of Public Opinion in the course of its regular series of public opinion polls, the question involved being: "do you ever have occasion to use any alcoholic beverages such as liquor, wine or beer, or are you a total abstainer?" This question has not been asked every year; however since the national proportion of users in a poll taken in 1945 was the same as in that taken in 1948 it is assumed that the same proportion applied in 1946, and that the same proportions would apply to the Ontario portion of any estimate for 1946. On this basis the percentage using alcohol has increased from 65% to 71% during the period under review, representing a proportionate increase based on the earlier year of 9.2%. Making allowance for general population trends this represents the addition of close to 600,000 to Ontario's drinking population[4]. The beverage alcohol consumption rate in terms of gallons of alcohol equiva-

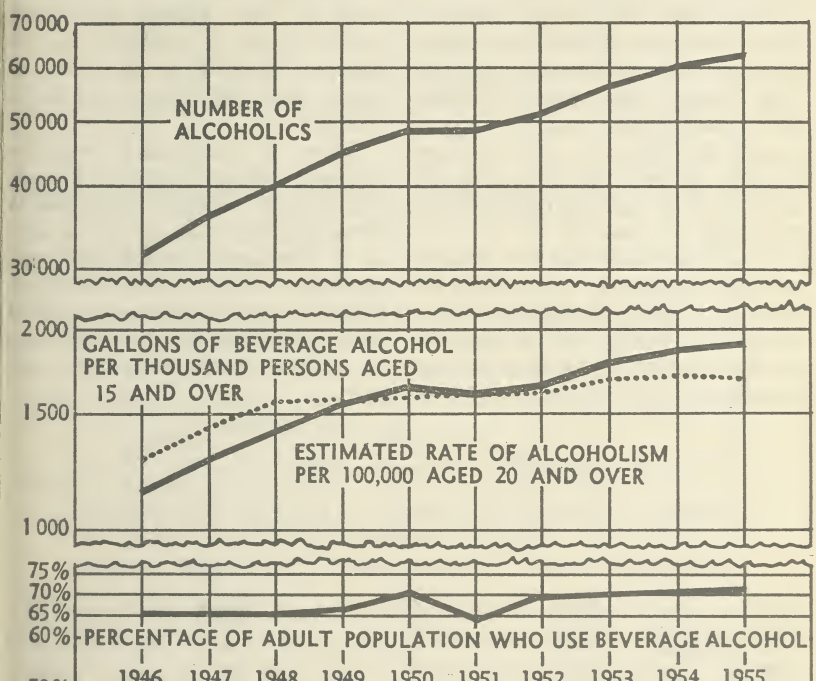
(3) While figures on some of the factors are available up to and including 1956, the technique of estimating prevalence of alcoholism makes use of centred two-year moving averages; hence the last year for which estimates of alcoholism can be presented is 1955.

lent per capita aged 15 and over has risen from 1.28 gallons to 1.69 gallons during the period, an increase of 32.1%, while a similar comparison based on the estimated population of alcohol users only shows an increase of 20.3%.

The trends discussed above based on the data in Table I are shown graphically below in Chart A which has been plotted on a proportionate scale

CHART A

Trends in Alcoholism and Alcohol Consumption — Ontario 1946-1955



(4) *While the Canadian Institute of Public Opinion's sample is based on the voting age population, it is being assumed from the result of a number of studies in the United States and Canada that a sizeable proportion of those in the 15-20 age group also use alcohol. Taking all known facts into consideration it was felt that estimates based on the population 15 years old and up were likely to be closer to the correct figure than estimates based on the adult population only.*

Drinking Preferences

It is widely believed that drinking preferences between various different types of beverages have something to do with the prevalence of alcoholism. While no data are available on proportions of the population which customarily use more or less of any particular kind of beverage, the gallonage of beverage alcohol sold in the forms of beer, wine and spirits have been estimated over an extended period. The figures for Ontario during the decade under review are presented in Table II, and are also shown charted on proportionate scale so as to indicate relative rates of change on Chart B

It will be noted that the amount of alcohol consumed in the form of wine rose and fell slightly during the period, ending up just about at the level where it started. Allowing for the over-all increase in the total of alcohol consumed in all forms this was actually a substantial decline in the contribution of wine to the total consumption of alcohol from 8.6% at the beginning to 5.5% at the end. Over the same period alcohol consumption in the forms of beer and spirits increased substantially so that the market share of beer alcohol rose from 64.5% to 66.5% while the market share of alcohol in the form of spirits increased from 26.9% to 28.0%.

There is considerable variation between different parts of Canada and between different countries in these drinking preferences as well as in per capita consumption and estimated rates of alcoholism. Charts C and D illustrate some of these differences for the latest years in which comparable data are available.

TABLE II

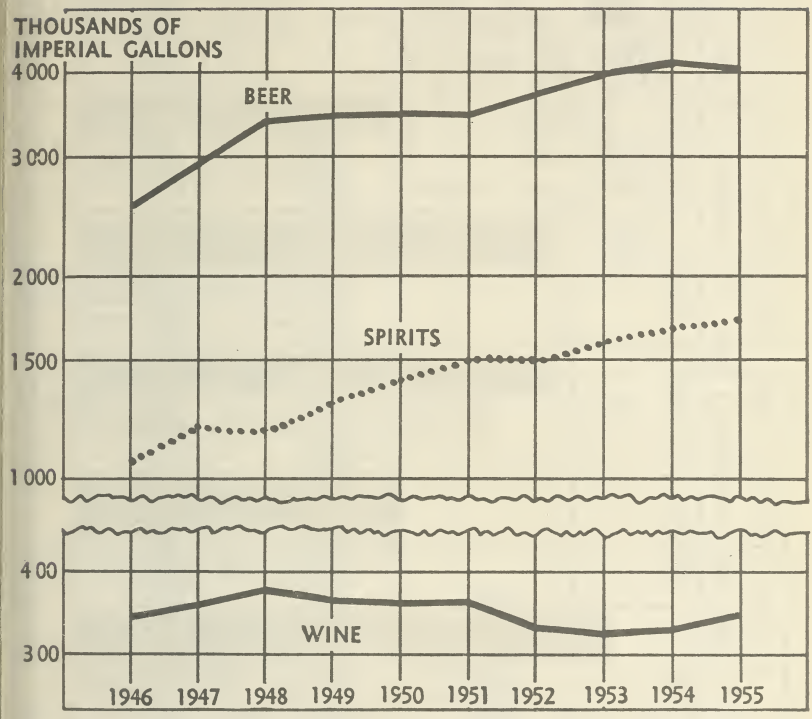
Gallonage of Absolute Alcohol Consumed in Ontario by Type of Beverage 1946-1955

(expressed in thousands of imperial gallons of pure alcohol equivalent)

Year	Beer	Wine	Spirits	Total
1946	2,552.5	342.2	1,064.4	3,959.1
1947	2,945.4	355.7	1,196.1	4,497.2
1948	3,408.1	375.3	1,186.6	4,497.2
1949	3,479.3	362.9	1,297.9	5,140.1
1950	3,499.9	359.3	1,399.7	5,258.9
1951	3,490.3	362.0	1,495.8	5,348.1
1952	3,733.3	331.4	1,503.0	5,567.7
1953	4,016.4	323.3	1,606.0	5,945.7
1954	4,180.2	327.0	1,684.8	6,192.0
1955	4,099.1	341.4	1,726.2	6,166.7

CHART B

Trends in Beverage Preference — Ontario 1946-55



In interpreting charts C and D it should be borne in mind that total consumption per capita of a particular type of beverage is not necessarily proportionate to the total consumption of only one type of beverage per user of that type. In addition account should be taken of known and unknown variations between areas and countries in the circumstances under which various beverages are consumed, for example the known fact that Italian drinking is confined far more to meal times than is French drinking.

CHART "C"
ALCOHOLISM RATES, PER CAPITA CONSUMPTION OF ALCOHOL AND TYPES OF BEVERAGE USED CANADA AND REGIONS—1955
ALCOHOLISM SCALE
2000
1500
1000
500
ESTIMATED RATE OF ALCOHOLISM PER 100,000 AGED 20 AND OVER
ALCOHOLISM
ALCOHOL CONSUMPTION
BEER
WINE
SPIRITS
NEW FOUNDLAND
MARITIMES
QUEBEC
ONTARIO
PRAIRIES
B.C.
CANADA
0.78
60.8%
3.9%
35.3%
810
0.92
48.1%
11.9%
40%
1260
1.24
66.2%
6.9%
26.9%
1910
1.69
66.5%
5.5%
28%
1900
1.30
63.3%
5.9%
30.8%
1305
1.53
50.6%
5.9%
43.9%
2190
1.39
63.5%
6.5%
30%
1750
2.0
1.5
1.0
0.5
ALCOHOL CONSUMPTION SCALE IN GALLONS
GALLONS OF ALCOHOL CONSUMED PER CAPITA AGED 15 AND OVER

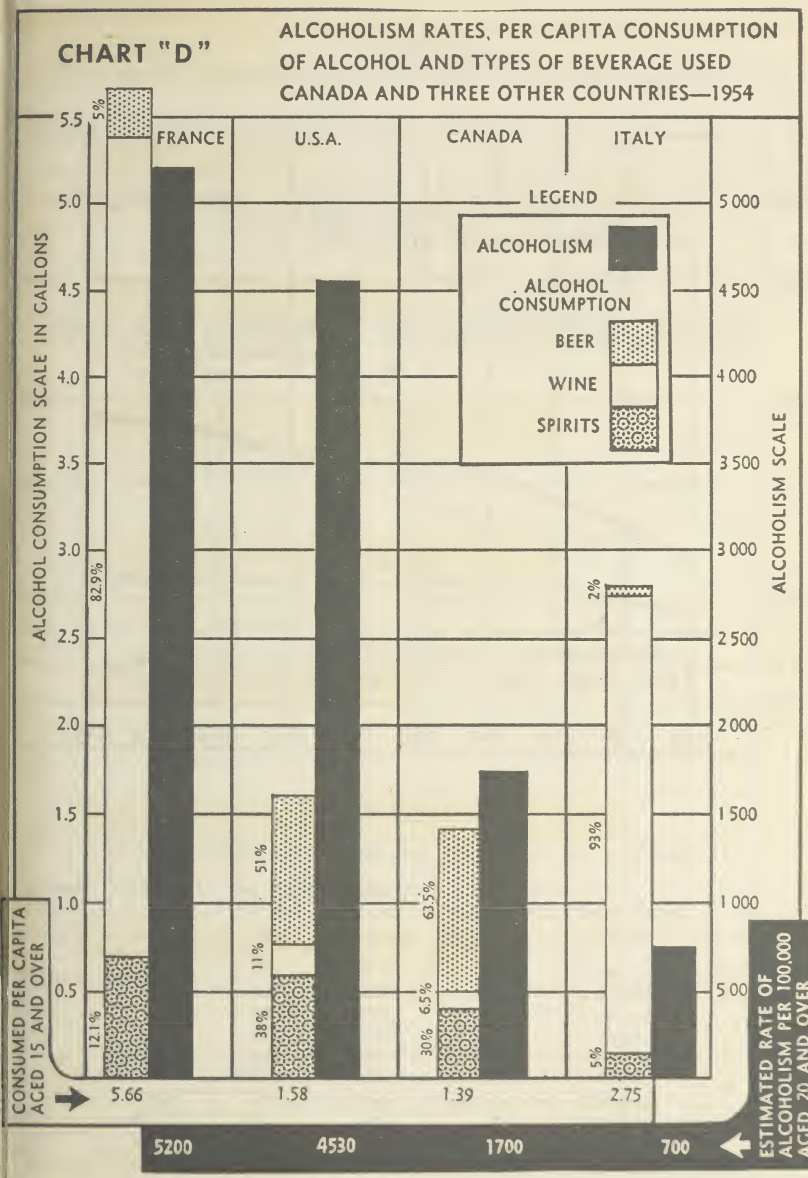


CHART "D"
ALCOHOLISM RATES, PER CAPITA CONSUMPTION OF ALCOHOL AND TYPES OF BEVERAGE USED CANADA AND THREE OTHER COUNTRIES—1954
FRANCE
U.S.A.
CANADA
ITALY
LEGEND
ALCOHOLISM
ALCOHOL CONSUMPTION
BEER
WINE
SPIRITS
ALCOHOL CONSUMPTION SCALE IN GALLONS
ALCOHOLISM SCALE
5.5
5.0
4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
5 000
4 500
4 000
3 500
3 000
2 500
2 000
1 500
1 000
5 00
5%
82.9%
12.1%
51%
11%
38%
63.5%
6.5%
30%
2%
93%
5%
CONSUMED PER CAPITA AGED 15 AND OVER
5.66
1.58
1.39
2.75
5200
4530
1700
700
ESTIMATED RATE OF ALCOHOLISM PER 100,000 AGED 20 AND OVER

CHART E

Comparison of Alcoholism Trend With Various Conviction Rates — Ontario 1946-55

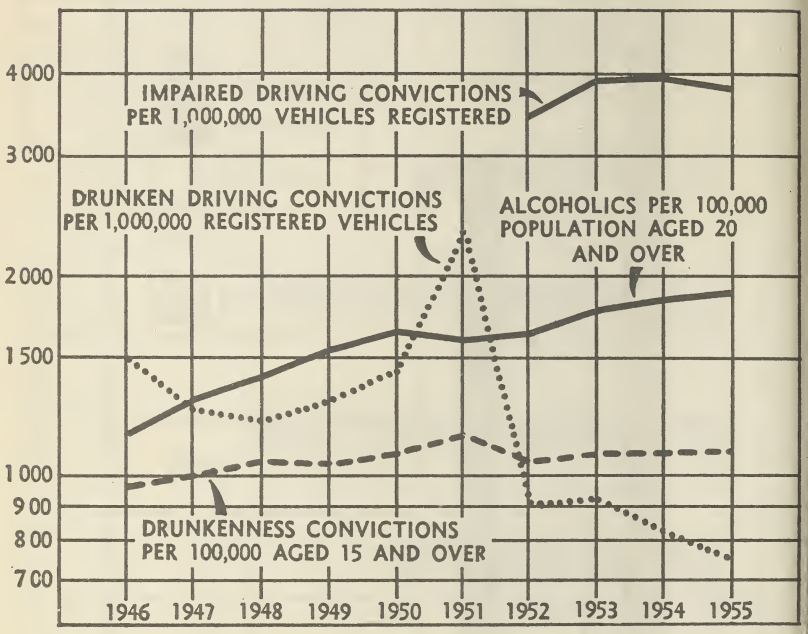


TABLE III

Convictions for Drunkenness and Drunken and Impaired Driving

Year	Drunkenness Number	Rate per 100,000 aged 15 and over	Drunken Driving Number	Rate per 100,000 vehicles	Impaired Driving Number	Rate per 100,000 Vehicles
1946	29,698	962	1,057	149	—	—
1947	31,218	996	1,009	126	—	—
1948	33,446	1,050	1,070	122	—	—
1949	33,797	1,042	1,249	129	—	—
1950	35,356	1,072	1,588	144	—	—
1951	38,577	1,149	2,822	234	—	—
1952	36,344	1,051	1,174	91	4,471	346
1953	38,108	1,083	1,295	92	5,518	392
1954	38,461	1,070	1,232	83	5,919	397
1955	39,465	1,079	1,229	76	6,244	386

Convictions

The trend in the rate of alcoholism can also be compared with comparable conviction rates for drunkenness as shown in Table III and Chart E. It will be seen that the alcoholism rate increases much more sharply than the rate for drunkenness convictions. Also shown are rates per 100,000 motor vehicles of convictions for drunken and impaired driving. The change in legislation in the middle of the period (when the lesser offence of impaired driving was first introduced) makes for some difficulty in interpreting the trend in this type of offence during the decade.

CHART F

Comparison of Alcoholism Trend With Rates of Mental Hospital Admissions for Alcoholism and of Cirrhosis Deaths — Ontario 1950-55

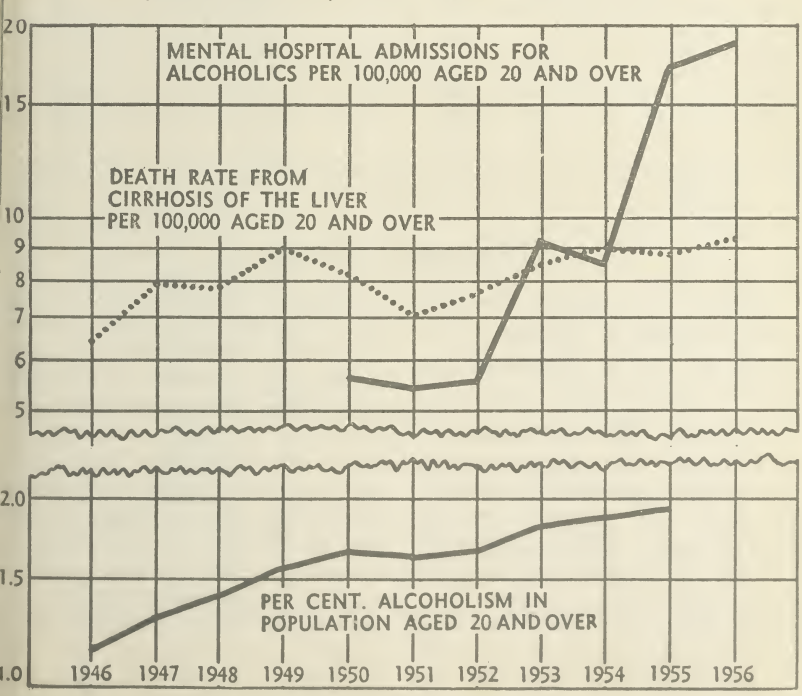


Chart F shows for a shorter period the rate of admission for alcoholism to mental hospitals, in comparison with the death rate from cirrhosis of the liver and the alcoholism prevalence rate. A number of possible reasons for the sharp upward trend in mental hospital admissions for alcoholics were discussed in the June 1955 issue of 'ALCOHOLISM' by Robert E. Popham, M.A. of the Alcoholism Research Foundation.

TABLE IV

Comparison between Mental Hospital admissions, Cirrhosis of the liver death rates and prevalence of alcoholism

Year	(a) Mental Hospital Admissions	(b) Cirrhosis of the Liver death rates	(c) Prevalence of Alcoholism
1946	—	6.4	1.15
1947	—	7.8	1.28
1948	—	7.8	1.40
1949	—	8.9	1.54
1950	5.6	8.2	1.64
1951	5.4	7.1	1.60
1952	6.0	7.6	1.64
1953	9.1	8.4	1.78
1954	8.5	8.9	1.86
1955	17.0	8.8	1.90

Economic Factors

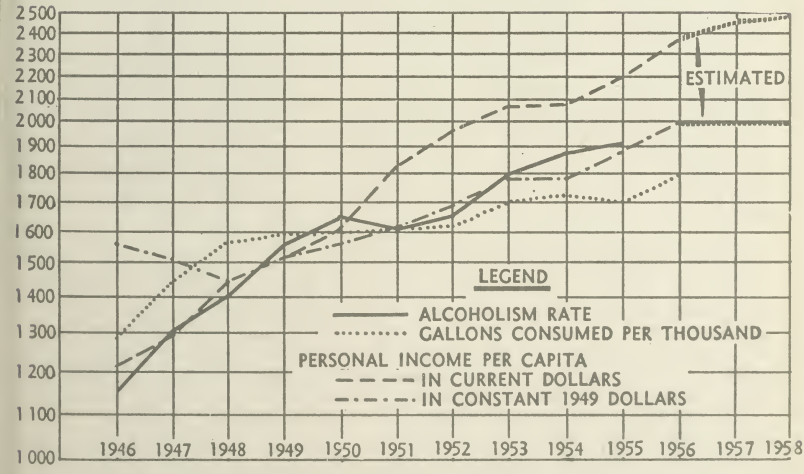
Finally the statistics available make possible a comparison between the rate of alcoholism and some economic trends during the same period. These are presented in Table IV which shows (a) gallons of beverage alcohol consumed per capita aged 15 and over, (b) total personal income, in current dollars, (c) the same expressed per capita aged 15 and over, and (d) the consumer price index. On Chart G the resulting trends are presented on a proportionate scale with the addition of further curves showing the alcoholism rate, and also of one for personal income per capita converted from current (inflating) dollars into (constant) 1949 dollars. The extremely close fit between certain of these curves does not necessarily indicate any causal relationship between these factors and the estimates of prevalence of alcoholism. However it is apparent that, if small annual deviations are ignored, the rate of alcoholism does parallel very closely the trend of real personal income per capita.

Comparison between the rate of alcoholism and some economic trends
Ontario 1946-1955

Year	(a) consumed per Gals. of alcohol capita aged 15 and over	(b) total personal income current $. (millions)	(c) total personal income per capita aged 15 and over	(d) Consumer Price Index (National)
1946	1.28	3,738	1,210	77.5
1947	1.43	4,017	1,280	84.8
1948	1.56	4,570	1,435	97.0
1949	1.58	4,904	1,510	100.0
1950	1.59	5,285	1,600	102.9
1951	1.59	6,093	1,815	113.7
1952	1.61	6,749	1,950	116.5
1953	1.69	7,209	2,050	115.5
1954	1.72	7,397	2,055	116.2
1955	1.69	7,951	2,175	116.4

CHART G

Alcoholism Trend Compared with Selected Economic Trends — Ontario 1946-55



Some 16 mm Films Available For Group Showings in Ontario

PROFILE OF A PROBLEM DRINKER

NFB 1957—29 minutes, b&w

In telling the story of David Spear this film looks beyond the familiar picture of the alcoholic to the insecurities and inner motivations that cause a man to lean on alcohol. David began his business career as a sober, serious-minded young architect with a promising future. He began to drink, however, and soon liquor became so important to him that it threatened his job and his home life. The doctor to whom he finally turned to for help explains the medical and other resources available to him in his struggle for recovery, and helps him to an understanding of the real reasons behind his uncontrolled drinking.

TO YOUR HEALTH

WHO 1956—10 minutes, color

The best, short, comprehensive film about alcoholism for groups of all ages and interests—professional and lay. Done in a stylized animation it uses all the resources of the medium to achieve maximum impact. Technical advisor was Dr. E. M. Jellinek. Shows both the acceptable, traditional, social uses of alcoholics beverages and the pathological use by alcoholics. It is scrupulously unbiased on the wet vs. dry controversy.

WHAT ABOUT ALCOHOLISM

Raymond McCarthy—Young America Films, 10 minutes, b&w

Shows a group of high school students in class discussing alcoholism. They decide to go out into the community to find out more about this serious problem. The youngsters seek information at an alcoholism clinic, from a judge, from an industrial employment manager, and at home from two sets of parents. They report back to the class on their findings, and conflicting views are voiced. The question is not resolved, but is left deliberately up in the air to provoke audience discussion.

WHAT ABOUT DRINKING

Raymond McCarthy—Young America Films, 10 minutes, b&w

Presents a number of different viewpoints of young people regarding drinking, none of which is labelled either "right" or "wrong". Not an informational film it is intended to stimulate discussion and allow young people to clarify their own thinking. Personal opinions by a discussion leader would negate intent of the film. Should be carefully previewed. Excellent for beginning a unit on alcohol education, and is most appropriate for small discussion centred groups.

For loan of prints contact Education Department
Alcoholism Research Foundation, 9 Bedford Road, Toronto 5.

Vol. 5, No. 4, December, 1958

IENCE & MEDICINE DIVISION

lcoholism

RESEARCH

REATMENT

DUCATION

TABLE OF CONTENTS

This periodical is published five times a year in the interests of a deeper understanding of the widespread disorder alcoholism.

Each issue contains pertinent, factual information selected primarily because of its interest to those who are called upon to deal with alcoholism professionally. Articles published do not necessarily represent the views of the Foundation.

If you would like to receive this publication regularly, or if you wish additional information about some aspect of alcoholism, you are invited to write to the Alcoholism Research Foundation, 9 Bedford Road, Toronto 5, Ontario.

There are also branch offices at:

1 Duke St., Hamilton
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481 Queens Ave., London
1206 Bank St., Ottawa

Circulation of this issue: 10,(

Vol. 5, No. 4
December, 1958

alcoholism

RESEARCH

TREATMENT

EDUCATION

Executive Discusses Industry's Role In Dealing With Employee Alcoholism

*By Dr. W. H. Cruickshank**

It is believed that as many as 6 per cent of the working population are alcoholics — or people with drinking problems, with about five times as many men affected as women. They tend to fall into the 35-55 age group, members that is of what should be the most productive section of our population. In general, it has been observed that an alcoholic in industry averages 18 days a year away from the job, four times more than the normal person, and the cost to Canadian industry as a whole has been put at $100,000,000 a year. It is no small problem.

Let us look at this from the human point of view, and define just what is meant by an alcoholic. The skid row type of alcoholic is a small minority, seldom seen in industry.

**Dr. W. H. Cruickshank, Vice President and General Manager, Toronto Area, of The Bell Telephone Company of Canada Ltd., recently addressed the New Orleans Area Council on Alcoholism on this topic. With his kind permission we reproduce here a portion of that address.*

The kind of person we are considering a problem in industry may be a craftsman, a foreman or a quite senior executive, or his secretary. When he is sober, he is usually capable of doing an excellent job. In fact, I think the phrase 'problem' drinker is a better definition than alcoholic. For he is a man who cannot handle his drinking, who gets drunk once he starts — however excellent his reasons, when sober, for not touching the stuff. And it is a fact that no one in this category can ever seem to be a moderate drinker. Any ultimate cure must be based on life without alcohol.

What are the other characteristics of problem drinkers? It is very hard to find much that is specific. For they seem to be, for the most part, relatively ordinary people, as a group probably a little more intelligent than the average. We find seclusive and gregarious problem drinkers, energetic and lazy, religious and agnostic, successful and ineffectual. Some drink because they are bored, some because they have too much responsibility.

Urge to Escape

But there does seem to be general agreement among the experts on the subject that somewhere, for some reason, there is a basic immaturity, a tremendous urge to escape from problems and tension through the anaesthesia of alcohol. The problem drinker is prone to give up the struggle to which Man is inevitably committed. Most of us will take a drink when we feel tired or troubled, but it doesn't become a routine or (what alcoholism in fact is) a disease.

One of the problems in arriving at a solution lies in the likely obscurity and complexity of psychological motives, apart entirely from the physical aspects of the disease. But let us look at some of the more clearly apparent causes of alcoholism which we may encounter among our associates in industry. First probably is the predisposition.

Predisposing Causes

There are difficulties of family life, relationships that frustrate or enrage because of their inherent wrongness or because the individual is ill-equipped to cope with them. In the latter case we can probably see an effect of an insecure childhood. Perhaps the most important thing to remember is that the employer has to deal with the total man, not just the workman at the bench or the supervisor at his desk. The other aspects of life can so easily affect working ability. I do not just mean the physical details but the whole mental, you might say spiritual makeup. While this is no excuse for heavy-handed paternalism, it is perhaps an encouragement to leadership and sensitive understanding.

Let us turn now to the job situation. Boredom can certainly be a cause, the utter lack of challenge of

a particular job for a particular individual. That may be because he is a square peg in a round hole, something comparatively easy to rectify. It may also be because he has a false idea of his own capabilities, a greater problem. Then boredom is allied with frustration.

On the other hand, the job can be too much for a man. He may be obsessed by his inadequacy to fill it. Again, the reason can be real or illusory. Perhaps it is beyond his capacity, or it may just be that he has a wrong slant on what is expected of him.

In most cases, something can be done about the situation at the job-level, but that will not necessarily do away with a predisposition to a real disease. You may indeed find that the working problem was just the last straw that broke the camel's back, and the man soon selects another straw.

I would mention here too the influence of society. Most of our bad habits we pick up from our friends —probably our good ones too. A boy who gets among a set of drinkers — and has a weakness that way — will be in trouble. You might find a close parallel to the risk of alcoholism here in the risk of homo-sexuality in similar circumstances. Or, to be less serious, of addiction to golf.

I sometimes feel that the experts, so close to the details of the problem, do not pay enough attention to the significance of the times we live in. We live in a pretty materialistic civilization, a civilization of uncertain values, of very little real faith, and threatened daily with hideous destruction. There are individuals who are strong enough — or it may be, so limited in their interests — that they are not affected by this situation. But I suspect it has a very great influence on our young, on the rise of juvenile delinquency, which like alcoholism is a social, economic and moral problem. There is then in our way of life an overall reason to "drive a man to drink". Most of us can face up to that situation, or find other escapes from it. But it is surely something a man may wish to escape from — just as much as a nagging wife or a job that demands too much from him, or gives him no source of satisfaction.

Frustration and Guilt

The psychologists use certain generalized descriptions which are, I think, helpful to our understanding of the problem. They lay emphasis on frustration, and it can clearly be a cause of great stress. They also pay close attention to the alcoholic's rising sense of guilt. What he is doing, offends his own moral sense as much as that of the society he lives in, but he lacks the strength to stop. Thus the guilt increases as his likelihood of escaping from his burden recedes. And a cure — in the sense we have used the word (total abstaining) — depends on breaking this chain of guilt.

Interdependency

Another concept that I find of great interest is that of loneliness. The problem drinker is viewed as a man forced in upon himself, who drinks — in a way — to escape the inadequacy of his own company, to make up for the human contacts he has lost outside. To get the man back as an integral part of society, it is felt, is the key to his rehabilitation. I think this is undoubtedly true of the more or less advanced alcoholic; but I am not entirely convinced of the validity of this approach. Some of us are more gregarious, others more retiring, but we all have to develop social relationships fitting our own temperament. It may be the other directedness of our present society, the emphasis placed on the importance of getting along with people that actually creates the strain on the potential alcoholic. If there were less emphasis placed on his need to integrate, to adjust, he might be a happier, more balanced person. Maybe here we come closer to the core of the entire problem: The need for ever increasing interdependency of people, communities and countries may be one of the most potent tension-producing results of industrialization.

For many alcoholism has appeared primarily a moral issue. It is wrong to get drunk and people who do should be punished. This seems to be based on two attitudes: the need to protect society from the discomfort of encountering alcoholics and the sense that such self-indulgence is an actual sin. Penal laws with regard to public drunkenness have their origin in the moral view, they are sterner in countries with a strong puritan tradition. But generally they tend to be tempered by mercy — and the weariness of the law-givers. So far as limiting alcoholism is concerned, I do not believe that discipline can achieve much — by itself. Yet it is certainly a necessary element in a well-balanced policy.

Closely allied to the moral view is the religious, the appeal to the alcoholic through his sense of something greater than man and his own p e r s o n a l situation — some Higher power as Alcoholics Anonymous puts it — I am not thinking here so much of the threat of damnation for his sins, but of the wider fields of inspiration. The attitude which, I believe, has a lot to do with the great success of Alcoholics Anonymous is the concept of helping others. Again, depending on the personality and background of the individual, this may well lead to control, or share in the achievement of it.

Then there is the psychological approach, the actual treatment of the individual by a variety of schools, the attempt to uncover and clarify basic personality factors. The methods vary according to the person treated and the enthusiasms of the profession at a particular time.

Again, provided a thorough job is done, through self-understanding, many are assisted. However there are also many who resent being psychoanalyzed.

And I would just mention here the need for the non-professional, the friend or member of the family — or the boss on the job — to be aware of certain elementary facts about the alcoholic's psychology. The principles according to which the professional works should influence his own efforts; he should be aware of the depth and nature of the patient's guilt, and beware of rendering it yet more unbearable.

Finally there is the medical approach, the clinical treatment of the physical aspects of the disease, and the medical means of reducing — at least for a time — the temptation to drink. Antabuse and other similar treatments can make a great contribution to dealing with a drinking problem, but they leave the psychological origin untouched, and nothing is likely to be permanent unless remedial work is done here too.

Industry

We come to the question now — where does industry fit into the picture? And this really is a composite of a number of more specific questions. What can industry do for the problem drinker? Is it worthwhile doing anything at all? What approaches offer the best hopes of success?

First, let us consider the justification. There are the plain facts of lost time and lowered efficiency. The alcoholic becomes effective every Wednesday. By and large, it is not the very young who become problem drinkers in industry, but men of an age when they should be at their most productive. For 35 to 45 is the usual time when heavy drinking begins to get out of hand.

Costs

From the purely economic point of view, a great deal of money has likely been invested in their training and development. It will be a serious loss of skilled or management resources if they do not make the most of their careers, and it will be costly to replace them.

Of course, rehabilitation can be costly too and there is no assurance of success. There are, indeed, some who say that from a purely economic point of view the firm is better off to cut its losses, to dismiss or pension off the alcoholic who is no longer an asset to the company, for even a fifty-fifty chance of rehabilitation does not justify the cost of a serious program. But even if this could be done — and I question that it could — then surely less tangible considerations must be weighed in the balance — the company's responsibility to society — and to the individual, and its reputation as an employer.

At this point, having accepted the desirability of a formal program of help for the alcoholic, we can see three essential aspects. The first is

administrative. The company must have a definite program of aid, related to the handling of sickness benefits, disability pensions, etc. The second is medical, since there is a major part to be played by the company's medical department or doctor. The third is the on-the-job aspect, the role of boss and associates, and that seems to me the most important of all, for they can make or break any more specialised activity.

Began to See Need

Some eight or nine years ago we began to see the need for a formal program of dealing with this health problem. Our medical department was developing in size and competence at this time, and more employees were being referred to it for advice about all health problems, including their drinking habits. This provided our medical people with experience out of which to speak effectively to management; they were able to show that, at least in the early stages, it was possible to alter a man's drinking habits. Also, the committee which administers our benefit plan was aware that a number of employees were receiving sickness benefits for the treatment of alcoholism, but labelled something else without a moral stigma. And they could look back throuhg a file of superannuation cases where alcohol had been a major reason why the company had to pension a man early — and foresee other cases in the quite near future.

The turning point came with one particular case. I'd like to tell you the story —briefly. The man, a long term employee, was to be fired. His history of alcoholism went back twenty years. He'd been given a great deal of sympathetic understanding, many last chances but no really constructive assistance. He had been partially disabled as the result of an industrial accident, and that increased naturally the company's unwillingness to take final action. But a stage was reached when something had to be done. However, at the last moment the decision was made to send him to hospital on disability benefits. After some months of treatment it was decided — without too much confidence — to take him back on the job. To everyone's surprise and admiration, he again became a valued employee — and henceforth a dry one.

Policy Adopted

We have a tendency in the telephone company — with our wide and rather complex operations — to put policies down on paper. So in 1951 the following policy was officially adopted:

1. That it be recognized that most cases of alcoholism or "problem drinking" present a health problem.

2. That each case of incipient or suspected alcoholism or "problem drinking" be encouraged to seek adequate medical investigation without delay.

3. That each case involving a health problem be considered eligible for sickness disability benefits or a disability pension under the company's plan for employees' pensions and disability benefits, if the condition is sufficiently advanced to produce disablement from work.

You will note that final disciplinary action has no place in the policy except as a last resort. But that does not mean temporary disciplinary action cannot be used, and it has proved useful in certain cases, acting as a motivating force after other, more constructive methods have failed.

Implementation

A general policy like this must be implemented on two levels. There is the organization of the medical department to deal with the problem drinker. Given trained and interested personnel, that is no great chore. The major task is to educate supervision to a policy-inspired view of any cases within their authority. The finest policies can fall flat on their face in a large organization unless middle and lower management wish to carry them out.

Special attention was paid therefore to developing company-wide awareness of the policy and of the reasons for it. This had been done with other health problems. This development of a company-wide awareness must be a continuing process.

Communications

The policy was discussed in detail with top management, who in turn held discussions with their more senior people. Detailed explanations of purposes and procedures were given to the personnel supervisors in each department, and printed material was distributed among the employees — m a i n l y through existing company publications — to acquaint them with com-

pany thinking on the problem of alcoholism. In all this, a reasonably liberal attitude was taken, the aim being to get the employees to see alcoholism as primarily a health problem — and one where the company could be relied on for sympathetic assistance.

Since the policy was inaugurated some 300 cases have been referred to the medical department for advice, and worth-while results have been achieved in over half of these. Numerous others have been handled by supervision working along constructive lines on their own and Alcoholics Anonymous have been of wonderful assistance. I would say here that there has been — there can be — no standardized scheme of management. In some cases, actual medical treatment was required, normally hospitalization or a period in a sanitorium. In others, group or personal discussion alone seemed indicated. In others, reference to Alcoholics Anonymous seemed the most satisfactory procedure. But I would emphasize that one could get nowhere at all without the co-operation, even the grudging co-operation of the individual. He had to recognize the problem. It might well be that he preferred — out of pride or temperament — to handle it by himself, sometimes with success — He might take advantage of the aid of AA or of company personnel people, but nothing was to be gained by trying to force a man into a personality pattern that was alien to him.

Some Success

One would not claim that Bell of Canada is now free of problem drinkers. No company of any size is. We have had our failures: sometimes dismissal was the only solution, and that in itself may have provided the final shock that led to wisdom. I know this has happened more than once. There have been cases too where a man of promise in management has had to be placed in a less responsible position, in a job where his drinking habits would not interfere too seriously with his efficiency. And there are undoubtedly cases which have not come to light. But, on the purely practical level, the company is satisfied that the program has been largely justified through the reduction in absenteeism and in necessary separations which were required.

As I indicated earlier, we must see rising alcoholism as a product of the problems of adjustment to our present society — maybe of the problems of adjustment of man to any society, for it is peculiar to neither our age nor our continent. But the stresses of modern industrial life do play a part in the problem drinking which afflicts the employees of an industrial organization, but something can be done about them. Perhaps education is required, perhaps a revision of duties or business relationships. Even our greater leisure and higher standards of living may be part of the trouble. We have more time for

drinking and more money to buy alcohol — unless we are aware of better ways of spending both.

Responsibility

A great deal is said these days about the responsibility of industry — of business in general — to society. We who work for public utilities such as a telephone company are most keenly aware of this responsibility. Our ability to continue in operation does indeed depend on public agreement that we are serving efficiently and acting with good citizenship. No industry can long escape such a duty. To my mind the careful attention to the problem drinker by the organization is part of such good citizenship. That does not mean softness beyond the limit of reasonable assistance, but it does mean the effective use of human assets. Can industry afford to do anything about the problem. In my opinion it cannot afford not to. Nor can the industrial community.

New Law For Compulsory Treatment Proposed By Medico-Legal Society

The Medico-Legal Society of Toronto has recently, after prolonged study of the subject, submitted to the Attorney-General of Ontario a proposed new act of legislation to be known as 'The Habitue Act' which the Society urges should replace those sections of 'The Mental Hospitals Act' which deal specifically with persons addicted to alcohol or drugs.

In effect the proposed new legislation would make it possible to separate some aspects of handling alcoholics and drug addicts from problems of mental illness or defect. It would eventually remove the problem of handling non-psychotic alcoholics, either voluntary or committed, from the jurisdiction of the mental hospitals and provide for special institutions to which such persons could be treated.

In order for the proposed legislation (if enacted) to become effective, the necessary treatment institutions would have to be established. Existing treatment facilities, which handle only voluntary patients, are overloaded even now and could not cope with patients directed to them by any form of legal compulsion. Such involuntary patients can be dealt with at present only in mental hospitals; and as a result of several factors, there are therefore extremely few such patients (157 in 1956) receiving treatment of

any kind. Relatives, doctors, lawyers and judges are most reluctant to commit a person, who appears mentally normal apart from his addiction, to a mental hospital, and the mental hospital administrators are reluctant to receive them.

Quite apart from any reluctance to contemplate placing an addict in a mental hospital, the procedure that now exists in effect places on the addict's family the burden of initiating any such proceedings. Because of the ill will that this might engender within the family such action often appears to be likely to do more harm than good. In addition, it involves practically a full lawsuit with the family in the role of prosecutor and the addict as the accused and must come before a county judge. The length of time involved — usually at least two weeks — defeats any possible effort to push an addict into treatment at a time of crisis when he might be most amendable to it. It also often results in proceedings being dropped half way through the endeavour; the addict sobers up temporarily, only to have the alcoholic behaviour begin again shortly after.

An Illness

As pointed out in the Medico-Legal Society's brief, it is now generally accepted that:

(1) Alcoholism and sedative addiction are diseases, and as such may be treated.

(2) Fines and imprisonment are not usually of much or any help.

(3) Addicts of any kind respond much better to treatment when caught in the early stages of addiction than they do later on.

(4) Treatment of addicts may require psychological, social and physical medical care.

(5) Effective treatment requires early, immediate, continuous and long-term control of the patient, but not necessarily confinement.

Only a small fraction of Ontario's 70,000-odd alcoholics are presently coming into voluntary treatment at special clinics, or through private physicians or seeking effectively any aid from clergymen, social workers or Alcoholics Anonymous. The rest continue to do incalculable damage to themselves and to those around them, whether these be wives, children and other relatives and friends or their co-workers and employers. The social losses are immense; yet apart from the little-used procedures for commitment to mental hospitals nothing can be done. In fact an alcoholic may terrorize his family but while he is in his own home the police can do nothing unless some member of the family or other person in the house will lay charges of

assault. And even in that case, the outcome of conviction will at present be not treatment but fines or imprisonment.

New Police Power

The proposed new legislation enables the police to arrest an alleged habitue in private as well as public places when it appears that he is under the influence of alcohol or drugs and is conducting himself in a manner which in a normal person would be disorderly. He would then be brought almost immediately before a magistrate, rather than waiting for an appointment before a county judge, and an investigation conducted (in chambers) to determine whether the person was in fact a habitue. It should be noted that magistrates by the nature of their office have in practice far more experience with drunks and habitues than do conuty judges.

Referrals

The proposed act will also enable a magistrate to refer a person suspected of being an addict for medical examination and to do so when such a person appears before him charged with any offence at all. This procedure is not at present available even to the county court judge to whom present petitions about habitues may be placed. The proposed procedure would facilitate early detection and treatment of persons who might otherwise continue to get worse.

Apart from this, the proposed act enables any person to lay an information before a justice of the peace that a person is a habitue; whereupon the justice of the peace may issue a warrant to have the alleged habitue brought before a magistrate in order to have an enquiry made respecting his condition. This provides a much less expensive and time-consuming procedure than the present plan of a petition before a county judge.

The proposed legislation also extends the time during which a

haibtue patient is under control (but not necessarily confined) by extending from six months to two years the period of probation after the patient's release from an institution.

It is expected that the existence of this proposed new framework for compulsory treatment will itself encourage more addicts to seek treatment voluntarily than are doing so at present. Existing facilities are equipped to deal with voluntary patients but not with those requiring confinement. The latter class need new and specialized facilities.

Define Habitue

The designation of habitue is defined in the proposed new act in the same way as is now defined in the Mental Hospitals Act. Under this law one is deemed an habitue if he is so given over to the use of alcohol, that he:

1) is unable to control himself
2) is incapable of managing his affairs
3) mis-manages his property
4) places his family in danger or distress
5) transacts his business prejudicially to the interest of his family or creditors
6) uses intoxicating liquors to such an extent as to render him dangerous to himself and others
7) incurs the danger of ruining his health and shortening his life thereby.

This is worded practically the same as it was in an act passed in 1873 "to provide for the establishment of an hospital for the reclamation and care of habitual drunkards." At that time, the asylum referred to was in fact built, but before long it was in use as a regular mental hospital rather than specifically for alcoholics. It is felt that the success of the proposed new legislation, 85 years later or more, depends on provision of adequate treatment facilities to enable the aims of its framers to be effectively carried out.

A.R.F.
ACTIVITY
NEWS

DECEMBER 1958

FOUNDATION LIBRARY ACQUIRES SPENCE AND JELLINEK COLLECTIONS

Dr. E. M. Jellinek, world-renowned scientific pioneer in alcoholism research, and Rev. Ben Spence, prominent Canadian temperance crusader, have both recently deeded to the Alcoholism Research Foundation their lifetime collections of books and papers in the alcohol field.

The members and staff of the Foundation are profoundly grateful for both these contributions. Assembled as they are from quite different viewpoints, each will form a separate section within the A.R.F.'s central research library on alcohol problems. In this way they will always be available for students of alcoholism and related subjects, particularly to the Foundation's own research staff.

Dr. Jellinek, recently retired as chief consultant on alcoholism to the World Health Organization, is now carrying on his research and writing in Toronto, as a consultant to the Alcoholism Research Foundation (Ontario), the Alcoholism Foundation of Alberta, and as Associate in the Department of Pschiatry, University of Toronto.

Rev. Ben Spence, now 91 years old, was for many years General Secretary of the Ontario Temperance Federation and is still actively interested in the field.

NEW MEMBERS OF FOUNDATION BOARDS

The Hon. R. L. Kellock, former Justice of the Supreme Court of Canada and at that time the Chairman of the Ottawa Board of the Alcoholism Research Foundation, has become a

member of the central Board of Trustees of the Foundation at Toronto. T. M. Gibson, who had been on the Board early in the Foundation's history has recently been re-appointed to the Board. A third new Board member is Dr. J. A. MacFarlane, Dean of Medicine, University of Toronto, and formerly the first Chairman of the Foundation's Medical Advisory Board. Dr. Arthur B. Kelly has retired from the Board. Dr. Oswald Hall, a University of Toronto sociologist, has joined the Medical Advisory Board.

B. R. Marshall, branch manager of the Royal Bank, has replaced the Hon. Mr. Justice Kellock as Chairman of the Foundation's Ottawa Board.

The Foundation's Hamilton Board has lost Thomas A. Jarvis, one of its original members, and has added Judge H. C. Arrell of the Hamilton Juvenile and Family Court. Meanwhile appointments to the Hamilton Medical Advisory Board (chaired by Dr. T. W. Tice) are: Dr. C. G. Beacock (psychiatrist), Dr. John C. Hall (psychiatrist), Dr. C. J. Jaimet, Dr. W. R. Webster, Dr. Allan Watts, Dr. J. W. Charters, Dr. C. L. Bates and Dr. Mary Purdy. R. Hartley Beattie, formerly probation officer with the Ontario government has been appointed Social Worker at the Hamilton Branch.

HOLD ALL-DAY SEMINAR ON ALCOHOLISM WITH SIR GEOFFREY VICKERS, V.C.

Senior professional staff of the Alcoholism Research Foundation, together with a few invited guests having interest in the public health field, recently took part in a special one-day seminar on the objectives of alcoholism research and education. Sir Geoffrey Vickers, a distinguished British solicitor, industrialist and social philosopher, led the discussion while Dr. A. B. Stokes, University of Toronto Professor of Psychiatry, was chairman.

After an opening paper by Sir Geoffrey, discussion ranged over a wide variety of topics including: the problems of combining research, education and action; the possibility of determining thresholds in relation to (a) the immediate effects of alcohol on behaviour and (b) the danger of developing addiction; the existence or no of an alcoholic or pre-alcoholic personality; legislation, folklore and possibilities for preven-

tion of alcoholism. A summary of this discussion is being prepared from recorded tapes and will be available for participants.

CANADIAN HONOURED

Dr. R. Gordon Bell, member of the Medical Advisory Board of the Alcoholism Research Foundation and director of his own Bell Clinic at Shadowbroow Hospital, Willowdale, has been awarded a Citation of Merit by the Malvern Institute for Alcoholic and Psychiatric Studies. The awarded was presented by Dr. C. Nelson Davis, Medical Director of the Malvern Institute, at the Institute's twelfth anniversary meeting at Malvern, Pennsylvania.

HOLD THIRD CLERGY WORKSHOP SERIES

Some 16 clergymen from various denominations took part this fall in the third annual series of six half-day workshops on alcoholism at Brookside Clinic. This is part of the Foundation's expanding efforts to provide various professions with the kind of information and understanding they need to work together in helping treat alcoholics.

Co-sponsored by the Foundation and by the Christian Social Council of Churches, this year's sessions included letters and discussions on: the personality of the alcoholic, the process of making referrals, pastoral counselling practices, communication problems and various community resources.

Out of the three annual workshops has emerged a group of "alumni" who are meeting every other month or so this winter to consult further on their problems as clergymen in dealing with alcoholism. Dr. E. M. Jellinek will lead one of these sessions and another will be taken by Robert J. Gibbins, one of the Foundation's Research Associates.

"WHEN A CHILD ASKS" RADIO PROGRAM HEARS SEVERAL WIVES OF ALCOHOLICS

During the week beginning Jan. 4 the 15-minute public service program "When a Child Asks", which is supplied weekly by the United Church to over 30 Canadian radio stations, will deal with problems of family upbringing as they are faced

by mothers whose husbands are alcoholics. In Ontario it will be heard over stations in Brockville, Kingston, Lindsay, Oshawa, St. Catharines, Niagara Falls, Kitchener, Timmins, Sudbury, Kenora, Port Arthur, Fort William, Tillsonburg and Fort Francis. Times and dates vary, but can be obtained by telephoning radio stations in these localities.

ONTARIO GROUP INVITED TO NAAAP RESEARCH CONFERENCE

The North American Association of Alcoholism Programs (of which the Alcoholism Research Foundation Executive Director, H. David Archibald is currently president) recently sponsored a two-day research conference at Washington. This was made possible by a grant of funds from the United States Goevrnment through its National Institute of Mental Health. Six delegates were invited from Ontario's Alcoholism Research Foundation, including H. D. Archibald, Dr. J. D. Armstrong, John R. Seeley, R. J. Gibbins, Wolfgang Schmidt (who presented a paper on Alcoholism, Drinking and Traffic Accidents) and Dr. J. M. Blackburn (who chaired the psychology session and summarized its discussions).

CANADIAN ALCOHOLISM PROGRAMS NOW FORMING NATIONAL ORGANIZATION

Directors of alcoholism in five Canadian provinces have applied for a Canadian Charter to set up a nation-wide body which can help to: foster sound, effective research; centralize and circulate research and other information on treatment and prevention; facilitate the growth of public education and professional training programs; provide a method of coordination between existing provincial programs; supply an independent source of adequate funds to finance worthwhile research anywhere in Canada.

Review Present State of Knowledge On Alcohol, Alcoholism and Driving

*by Reginald Smart & Wolfgang Schmidt**

"If you drive don't drink — if you drink don't drive" — this is a dictum commonly preached in the interests of highway safety. The constant use of this dictum implies that we are certain of the detrimental effects of alcohol on driving ability and that the problem of drinking and driving can be mitigated by simple suggestion. Despite our educational efforts the rate of convictions for impaired driving has increased steadily; perhaps then it is appropriate to examine the evidence for our assumptions.

This paper will indicate, briefly, the state of our knowledge about both the physiological effects of alcohol on the driver and the involvement of the drinking driver in accidents. A further question — which bears importantly on the efficacy of present highway safety programs — is whether alcohol addicts constitute a high risk group with regard to accidents, convictions and suspensions.

Except for some relatively recent work there is general agreement that the consumption of alcohol tends, essentially, to affect adversely the performance of any any psychomotor activity — be it driving, riding a bicycle or merely walking. The prime action of alcohol in the body is to depress the functions of the central nervous system. This is an anesthetic action essentially similar to that of ether or chloroform. The part of the brain affected and the degree of impairment depend upon the concentration of alcohol in the blood, and, therefore acting upon the brain. Although this depressant action is entirely on the brain, disturbance in behaviour is manifested in the organs controlled by the particular brain areas affected.

Effects of Amounts

In a person of average size (150 lb.), 2 or 3 ounces of whiskey present in the body will produce .05% alcohol in the blood. From a concentration as large as or larger than this, diminished inhibition and self restraint and impaired judgement result; many normal inhibitions

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**Revised from a talk given by Reginald Smart, Research Interne of the Alcoholism Research Foundation, at the 1958 Ontario Road Safety Workshops, sponsored by the Ontario Department of Transport. Wolfgang Schmidt is a Research Associate of the Foundation.*

vanish; some extra personal and social liberties are taken and there is an obvious blunting of self-criticism.

At a concentration of .10% alcohol (such as would result from 5-6 ounces of whiskey) motor areas of the brain are affected — the person sways perceptibly has difficulty performing simple motor tasks, and his vision is somewhat blurred. At this level there is a measurable reduction in sensitivity, impaired discrimination, and diminished speed of motor response, but frequently an inflated feeling of competence and self-confidence. With increasing concentrations of alcohol in the blood there is a corresponding progression of functional impairment in perceptual and sensori-motor abilities.

In order to study the incapacitating effects of various blood alcohol levels, the National Safety Council has set up a "Committee on Tests for Intoxication". This Committee has recommended that the following be accepted by legal and judicial bodies[2]: that levels below .05% indicate no impairment; between .05 and .10% a "questionable" impairment needing support by clinical data for a positive conclusion; and between .10 and .15 a "probable" impairment. Levels above .15%, it is proposed, be taken to indicate, in all persons, a definite impairment. These recommendations are followed, in most States allowing blood tests as evidence, and .15% is generally accepted as *prima facie* evidence* of impairment.

In Canada, persons who have the care or control of a motor vehicle while "drunk" or "impaired" may be charged under the Criminal Code. In cases of gross intoxication, the charge will most likely be for "drunk" driving, whereas in cases of less obvious intoxication, and especially those of borderline character, the driver will be charged with "impaired" driving.

Obtaining Evidence

How is evidence of impairment obtained? It is difficult to identify drivers who are under the influence of alcohol until some noticeable error in driving has been made or they become involved in accidents. This necessarily limits the efficacy of enforcement and control. A further and more serious limitation is the absence of legislation defining intoxication and impairment in terms of modern clinical testing.

The methods most commonly used in determining whether or not a person was intoxicated are an outgrowth of experience with

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**Defined in Osborn's Concise Law Dictionary as: "evidence of a fact which the court must take as proof of such fact unless disproved by further evidence".*

A GOOD FILM FOR NATIONAL HEALTH WEEK, FEB. 1-7, 1959

TO YOUR HEALTH — **WHO 1956—10 minutes, color**

The best, short, comprehensive film about alcoholism for groups of all ages and interests—professional and lay. Done in a stylized animation it uses all the resources of the medium to achieve maximum impact. Technical advisor was Dr. E. M. Jellinek. Shows both the acceptable, traditional, social uses of alcoholics beverages and the pathological use by alcoholics. It is scrupulously unbiased on the wet vs. dry controversy.

drunken persons and are related to actions, conducts, and appearances, in short, to external manifestations. These traditional methods however are not satisfactory for a number of reasons. The first is that there are few symptoms of alcoholic intoxication that cannot be simulated or reproduced by some other pathological condition[3]. The second is that, at the same degree of intoxication, various persons exhibit different symptoms[3]. A third difficulty is that such evidence frequently relies upon the quantity of alcohol consumed without considering factors such as weight, food in the stomach, rate of absorption of alcohol into the blood and individual oxidation rates—all of which influence the action of alcohol on the central nervous system. Lastly, it is extremely difficult to diagnose moderate intoxication on the basis of external manifestations alone.

Chemical Testing

The use of chemical testing as an additional means for assessing intoxication appears to be the best solution for these difficulties. Such testing has reached sufficient objectivity and reliability and there appears to be high agreement among medico-legal professions[4] on the corroborative value of these tests. Despite these considerations chemical testing of intoxication has been used only sporadically in Ontario. Although such test findings can be produced as evidence in courts, no suspect can be forced to submit to the tests. This prohibition is explained on the basis of legal safeguards against involuntary self-incrimination. Presently there seems to be general agreement in the medico-legal literature on this

point about self-incrimination. However, an earlier decision of a U.S. court[5] states that:

> "the prohibition of compelling a man in criminal court to be a witness against himself is a prohibtion of the use of physical or moral compulsion to extort communication from him not an exclusion of his body as evidence when it be material"

This principle has been accepted since the time when fingerprints were produced and admitted as evidence, and it would appear that there is no fundamental difference between finger printing and submitting to a chemical test of intoxication.

The most reliable test of intoxication, for forensic purposes, is the direct analysis of the amount of alcohol in the blood. Other methods using urine, breath or cerebrospinal fluid are based on known relationships between the concentration of alcohol in these substances and the concurrent concentration in the blood.

Contradictory Results

Although scientific and judicial efforts to determine the relation between blood-alcohol and impairment have been made, contradictory results necessitate a re-examination of the whole question of alcohol impairment. Although the "Committee on Tests for Intoxication" established .05% as the "non-impairment" level, several authors have found that some drivers are impaired at concentrations as low as .01%.[6] Popham and Smith[7] found that 39% of all drivers having blood alcohol levels in the .03 to .05 range of concentration made significantly more driving errors than non-drinking drivers.

Most studies of the effects of alcohol on behaviour have been concerned with the resulting degree of impairment. There appears to be an implicit assumption that *any* amount of alcohol either adversely affects performance, or leaves it unaffected. However, the seldom stated possibility that certain aspects of performance may improve at low blood alcohol levels has been explored with interesting results. Lucas et al[8] have speculated that a belief in the driver that alcohol adversely affects performance may result in his initiating compensatory action after a small intake of alcohol to guard against the expected deterioration in performance. Such a person, then, might proceed more slowly, take time to consider a problem more fully and finally respond more slowly and more accurately.

Pharmacological studies find that alcohol most readily disrupts inhibitory reflexes and that this drug serves to reduce tension, diminish self-criticism, nervousness, indecision and excitability. On the basis of these findings,

Miss M. D. Vogel[9], of the Alcoholism Research Foundation, hypothesized that alcohol, in small amounts, (.01-10%) might, where these tendencies exist in any unusual degree, actually assist in the performance of any task in which such tendencies are a hindrance. In fact, Miss Vogel's own work[9] has lent some plausibility to the view that low blood alcohol levels may actually improve the performance of a complex psychomotor task. Work on the facilitative effect of alcohol is admittedly preliminary and cannot yet be applied to driving. However it puts in serious doubt the belief that the sensori-motor functions of *all* persons are adversely affected at low blood alcohol levels.

Since the *main* body of pharmacological investigation indicates that alcohol impairs the types of activities involved in highway driving, attempts have been made to assess the role of the drinking driver in the precipitation of accidents. A careful study of all personal injury accidents in the summer of 1950[7] indicated that 23% of the drivers involved had more than a "trace" (i.e. more than .01%) of alcohol in their blood. It is believed that somewhat more fatal injury accidents than personal injury accidents involve drinking drivers but this problem has not been fully investigated.

The mere finding that drinking drivers are often involved in accidents is of little value unless their culpability *in* these accidents is known. Popham and Smith[7] attempted, on the basis of official accident reports to assign "relative contribution scores" to all drivers involved in personal injury accidents during the summer of 1950. The proportion of drivers having appreciable alcohol values (.01% or over) who were assigned high culpability scores was found to be significantly greater than in the group with no alcohol. It appears, from this study, that on the whole, drinking drivers are more "blameworthy" in accidents than non-drinking drivers involved in the *same* accidents.

Alcoholics

A further ramification of the "drinking driver" controversy concerns the possibility that alcoholics (as distinguished from normal persons who happen to have been drinking) are a high risk group with regard to accidents, traffic charges and licence suspensions. Our evidence on the traffic accidents of alcoholics[10] is not complete, but my cautious guess would be that approximately 6.3% of all accidents involve an alcoholic driver.[10] It has also been found that among persons convicted of drunk or impaired driving the frequency of persons who had at one time been treated for alcoholism is several times

greater than in the general population. A study in Sweden[11] found that over 45% of drinkers so convicted were persons whose drinking was a problem to both their families and to themselves. It is necessary then to entertain the hypothesis, for future careful research, that many drunk drivers are not merely momentarily drunk but are also alcoholics. If this is so, then the problem is as much a matter for treatment and preventive medicine as for legislation and educational devices such as "if you drive don't drink — if you drink don't drive".

Summary

The relationship between alcohol and driving is by no means completely understood. Our educational and social policies toward the consumption of alcohol and towards the alcoholic have so frequently outstripped our scientific knowledge that the whole problem is in need of restudy. Before rationally based steps, aimed at prevention, can justly be taken we urgently need to examine the warrant for our most commonly held assumptions about the actions of alcohol, about the effects of drinking, and about the sequelae to alcohol addiction.

At the present time the Alcoholism Research Foundation is making a preliminary attempt to determine the role in accidents and in convictions for drunk and impaired driving of the driver who is an alcoholic. A further attempt is being made to determine the importance of traffic accidents in precipitating alcoholics into treatment for their excessive drinking.

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Publish New Book of Alcohol Facts

Statistics of Alcohol Use and Alcoholism in Canada 1871-1956

It is estimated that in 1956 there were 180,990 alcoholics in Canada. This estimate is based on the widely accepted Jellinek Formula for computing total alcoholics in a population from the known smaller number of persons who die from cirrhosis of the liver, and is one of the alcohol facts in a large new compilation just published in book form for the Alcoholism Research Foundation by the University of Toronto Press. Authors are R. E. Popham, Assistant Research Director, and Wolfgang Schmidt, Research Associate, and the book is called "Statistics of Alcohol Use and Alcoholism in Canada, 1871-1956".

Rates of Alcoholism

The authors warn their readers that further work under way in the Research Department of the Alcoholism Research Foundation has raised (but not yet settled) some questions about the Jellinek Formula; consequently all prevalence estimates should be regarded as most tentative. Later revisions may well show the same relative order in the estimates, but call for somewhat higher absolute numbers in every case.

The Foundation's new comprehensive fact book deals not only with the illness alcoholism but also supplies figures from as far back as 1871 on Canadian alcohol consumption in various forms, alcohol-related crime and vital statistics. Estimates of the drinking and abstaining portions of the population are given for the postwar period with various breakdowns.

The estimated national total of 180,990 alcoholics represents a national rate of 1,890 alcoholics per 100,000 adults, a higher rate than in Norway, Finland, Australia, England or Italy, but lower than in Denmark, Sweden, Switzerland, Chile, U.S.A. or France, the only countries for which similar estimates have been made. Within Canada the provinces of British Columbia, Quebec and Ontario have corresponding rates of alcoholism that are above the national average, while all other provinces have lower than average rates.

Beverage References

Important shifts are shown in how Canadians distribute their beverage alcohol consumption between different drinks. For example, in 1871 out of a per capita consumption of 1.19 gallons (pure alcohol equivalent per person 15 years old or older) beer accounted for 15%, wine for 4% and spirits for 81%. By 1956, beer took 64½%, wine 5½% and spirits only 30% out of

a per capita consumption of 1.51 gallons.

Convictions

For every 100,000 people aged 15 and over there were 366 drunkenness convictions back in 1881; by 1913 there were 1,199; they then fell by 1933 to a low of 258 and have since risen to 882 per 100,000 in 1955. Newfoundland, Quebec and the Prairie Provinces have fewer drunkenness convictions per 100,000 while all other provinces have more than the national average rate.

Convictions for "keeping or operating an illicit still" have fallen from a high of 1,068 in 1923 to a low of zero in 1955.

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alcoholism

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This periodical is published five times a year in the interests of a deeper understanding of the widespread disorder alcoholism.

Each issue contains pertinent, factual information selected primarily because of its interest to those who are called upon to deal with alcoholism professionally. Articles published do not necessarily represent the views of the Foundation.

If you would like to receive this publication regularly, or if you wish additional information about some aspect of alcoholism, you are invited to write to the Alcoholism Research Foundation, 9 Bedford Road, Toronto 5, Ontario (WA. 3-2474)

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1206 Bank St., Ottawa (CE. 6-9717)

Circulation of this issue 11,000

Vol. 6, No. 1
April, 1959

alcoholism

RESEARCH

TREATMENT

EDUCATION

Summarize Recent American Research On Teen-age Drinking and Attitudes

*By George L. Maddox (condensed)**

THERE is still room for argument about whether the teen-ager should be praised or blamed for what he thinks about and does with alcohol. Fortunately, however, social science research is making it increasingly less necessary to guess about what he is thinking and doing, at least so far as the teen-ager in high school is concerned.

Systematic research on drinking in high school was begun in 1941 when R. G. McCarthy and E. M. Douglass made an exploratory study of attitudes toward the uses of beverage alcohol among students in suburban Washington, D.C. Replications of this study were made by the same authors in 1945 and 1947.[1] Then, between 1953 and 1956, three well-con-

**George L. Maddox is a professor of sociology at Millsaps College, Jackson, Miss. This article is condensed from a paper of his that was published in full in the December 1958 Newsletter of the Association for the Advancement of Instruction about Alcohol and Narcotics.*

ceived and coordinated studies of high school drinking behavior appeared under the auspices of the Mrs. John S. Sheppard Foundation. The first of these studies was made in Nassau County, Long Island, New York.[2] Studies in Racine County, Wisconsin,[3] and in Metropolitan Wichita and some non-metropolitan counties in Kansas[4] followed. During approximately this same period research was completed in selected areas of Utah[5] and Michigan.[6]

Cumulatively, over 8,000 teenagers in high school have been included in these studies. While this number is admittedly only a fraction of all students in American high schools and an even smaller fraction of the total number of all teen-agers, the cumulative sample provides the basis for generalizations about drinking in high school which are more substantial than impressionistic guesses.

Adult Example

The teen-ager in high school does not invent the idea of drinking; he learns it. Among the most important available models after which he patterns his behavior are prestigeful adults in his community. After all, the adult members of a society ordinarily are the ones who define and allocate privileges and tasks and the ones who mete out rewards and punishment for conformity and non-conformity. They not only define what is valued and disvalued behavior; they also pass on their definitions to their offspring by precept and example. Therefore, what adults typically say about and do with alcohol would be expected to define an important aspect of the image of adulthood after which adolescents increasingly model their own behavior. This expectation anticipates the most basic finding of research on drinking in high school: **The pattern and social context of drinking by high school students reflects to a marked degree the exposure of these adolescents to the pattern and social context of drinking among adults.**

When a high school student takes a close look at the behavior of adults around him, his chances are better than one in two of seeing a **user** of beverage alcohol. The term **user** here is defined so as to exclude those persons who use alcohol for religious purposes only and those whose use has been confined to an isolated or joking situation.

Surveys have rather consistently shown that about six in ten adults in the United States are **users.** Student imagery of adult drinking behavior is consistent with the survey data. In the Michigan study, for example, a majority of students, both **users** and **non-users,**

imagined the typical adult to be a user. In the Sheppard Foundation studies, the high proportion of students who reported one or both parents to be a user and that alcohol was available to them in the home also reflects the widely-shared image among high school teen-agers of drinking as expected adult behavior.

View as Social

Reflecting their observations of adult drinking behavior, these high school students in Michigan typically thought of and talked about alcohol as a social beverage rather than as a narcotic with predominant and necessarily anti-social consequences. What alcohol as a narcotic was said to do to the individual and the groups with which he is associated was countered by what it was thought to do for the individual and his group associations.

The use of beverage alcohol appears to be deeply entrenched in our social tradition. Custom relates drinking to sociability generally and specifically to the party and the celebration of special events. And some drinking is characteristically sanctioned by important social groups in the teen-ager's experience. Thus his competence to drink appropriately in various situations is one available means to demonstrate his increasing competence as a member of a society which has such drinking customs.

The reported image of the adult typically as a user and the predominant image of alcohol as a social beverage rather than as a drug anticipate the finding in every study of drinking in high school: **The most likely situation for the student's first exposure to alcohol is in the home in the presence of parents or other adults.** The usual age for this exposure is in the thirteenth or fourteenth year.

In the home situation the adolescent, if he is exposed to alcohol at all, is permitted a legitimate, though an admittedly premature, "playing at" or experimentation with this particular facet of adult role playing. Teen-age drinking in the home context, therefore, is properly conceived as a kind of anticipatory socialization into a pattern of behavior which is recognized as legitimate for young adults.

This implied legitimacy of teen-age experimentation with beverage alcohol in the presence of adults is at variance with assumptions frequently made about implacable parental opposition to drinking by their adolescent children. It is also at variance with the assumption that laws should and can limit the use of beverage alcohol to adults. For, not only do teen-agers in high school report

that their first exposure to alcohol is typically in the home context, they also report parental approval of this limited experimentation. For example, a majority of teen-age users in both the Wisconsin and New York studies report parental approval of some drinking at home and a sizeable minority make the same report in the Kansas study.

Conflict With Law

The imputed permissiveness of parental law with regard to drinking appears to undermine the laws of the community enacted to minimize or preclude the use of alcohol by minors. There is no indication in any study that such laws are, in fact, successful in keeping minors who desire to drink from drinking. More than this, the interview data of the Michigan study give no indication that students who violated state liquor laws were inclined to think of themselves as lawbreakers. On the contrary, there were frequent indications of a certain relish with which some students recounted their exploits in securing alcohol in violation of the law.

Insight into this interesting attitude toward laws enacted to control the use of beverage alcohol by minors is provided by an understanding of the typical student's view of the morality of drinking by his age peers. In the Michigan study, for example, only one in five students thought of teen-age drinking as absolutely morally wrong. The other four in five, including both users and non-users, preferred to think of it in terms of situational appropriateness or inappropriateness.

Most students could conceive of situations in which drinking would be morally acceptable for other teen-agers even if not for themselves. While those students who reported the greatest interest and participation in organized religion were also most likely to express absolute moral disapproval of teen-age drinking, a majority of those who expressed at least conditional moral approval also identified themselves with some church. This suggests that most of the students in the Michigan study had failed to grasp any necessary connection between being identified with a religious organization and being totally abstinent.

In any discussion of the process in which the teen-ager is taught and learns attitudes toward beverage alcohol it is important to emphasize that drinking behavior is never approved unconditionally by adults for themselves, much less for their minor children. Even when they give conditional approval to some premature teen-age experimentation with this facet of adult role play-

ing, however, adults do not insure themselves control over that experimentation. The Sheppard Foundation studies, which assess parental approval of student drinking, report that students frequently drink more than their parents know about, especially when they are with their age peers in situations not supervised by adults. Interview data from the Michigan study suggest why this is so.

Tasting vs. Drinking

In this study the high school student rather consistently referred to **tasting** alcohol with parents but to **drinking** it with their age peers. This distinction implies an awareness on the teen-ager's part that parental approval of controlled experimentation with "playing at" adult roles is not equivalent to parental approval of playing adult roles. In the presence of adults, teen-age drinking behavior is pre-mature and anticipatory. For the exploration of a wider range of experience in adult-like drinking, the student must ordinarily seek out his age peers.

Discussion of drinking behavior in teen-age peer groups often invites the inference that these peer groups exert an illegitimate but irresistible pressure on their abstinent members to become **users.** This is a half-truth at best. In the first place, although the teen-ager may practice drinking with his peers, he is as likely, if not more likely, to learn about drinking from observation of his parents or other adults rather than from his peers. Therefore, in many instances, peer groups only suggest that the teen-ager do prematurely what adults have already suggested that he may eventually do legitimately when he "comes of age."

"Coming of Age"

A basic problem of many teen-agers revolves, then, around just when a person "comes of age." The simple legalistic answer is, of course, that a person "comes of age" at twenty-one. This completely ignores the fact that adult-like responsibilities and role playing such as marriage, a full-time job that provides financial independence from parents, or entry into the armed forces have no particular relationship to a person's being twenty-one years of age. With each advancing grade of high school a larger and larger proportion of high school students drop out and assume such adult-like roles. Of those remaining who are finally graduated from high school, two of three will assume such roles almost immediately. Insofar as the teen-ager in high school typically thinks of the adult as a **user,** it is not particularly surprising to find that the proportion of **users** in high

school increases as graduation is approached.

In the absence of consensus among adults and teen-agers about precisely when one "comes of age," the teen-ager is observed to "play at" or play adult drinking roles before audiences of his age peers increasingly with age. He may **drink** with them rather than merely **taste** with them as he frequently must do in the presence of adults.

Peer Approval

Teen-age claims to adult drinking privileges are not always approved by teen-age peer groups, however. Sometimes these claims are considered to be as pre-mature by his peers as they are by adults. Teen-agers refer to pre-mature behavior of this kind as "acting smart." Yet, such disapproval tends to decrease with age so that, in the last year of high school, approval of some teen-age drinking will be given even by a majority of **non-users.**

This rather sanguine interpretation of teen-age group drinking is not proposed out of ignorance of some instances to the contrary. Peer groups do sometimes use drinking as a kind of hazing. Aspirants for group acceptance may be asked to violate adult prohibition against unsupervised drinking as an indication of good faith and loyalty to the group.

Some peer group drinking among immature teen-agers also unquestionably results in inebriety and related tragedies. Unsupervised drinking by teen-agers is legitimately disturbing to parents, if for no other reason, because it suggests the growing independence of the teen-ager in an area of behavior for which the parents cannot always assume that he is adequately prepared. Yet it should be re-emphasized that teen-age peer group drinking reflects exposure to adult drinking behavior and is considered illegitimate largely because it is premature.

Matter of Timing

Drinking in high school reflects to a marked degree the teen-ager's understanding of the adult world toward which he is moving. As the teen-ager in high school typically understands it, drinking seems to be a legitimate part of this world. His problem is not so much a matter of whether he may drink eventually if he likes but a matter of timing so as to avoid antagonizing adults or his age peers.

It is the rare student who is graduated from high school without at least one experimental taste of beverage alcohol.

Heavy Drinkers Rare

In spite of the fact that almost all upperclassmen in high school have at least experimented with drinking, frequent and intensive

drinking are atypical. In the various studies which have been under consideration here, estimates of the proportion of users—that is, excluding those persons who have used alcohol in an experimental joking way or for religious purposes only — have varied from one student in three to as many as eight students in ten. Yet estimates of the proportion of frequent or intensive drinkers—that is, those who average as much as one drink a day —have ranged between one student in fifty and one in sixteen.

All social behavior must be understood in terms of the social position of a member of society in relation to others in that society. Drinking behavior is no exception. Among high school students the chances that one will be a user increase with age and are higher for the male than for female. Different customs with regard to drinking are reflected in the higher proportion of users among urban in contrast to rural students and among Jewish and Catholic in contrast to Protestant students. Students at the extremes of socio-economic status are more likely to be users than those in the middle range of status.

"Alcohol Education"

This paper has summarized something of what we know about the "receivers" of alcohol education in high school. At the same time it has been pointed out that we know little about whether the receivers shift to another frequency when alcohol education is mentioned or what is received even when the frequency is not shifted since there is a striking absence of research on effectiveness of education in this area. For this reason it is relevant to mention here a small exploratory survey of what one group of high school students received when they were exposed to alcohol education.

A random sample of eighty students, approximately one-fourth of the entering class of freshmen in a church related, liberal arts college in Mississippi, were recently asked to report their exposure to what they recognized as alcohol education. They were then asked to indicate something of what they had learned about beverage alcohol as well as some of their attitudes

toward it and something about their use of it.

Seven in ten students claimed exposure to what they considered formal alcohol education in church school and six out of ten reported such exposure in public schools. The reported attitudes and use of beverage alcohol within the sample approximated the reported attitude and use patterns which have been observed in high school drinking studies generally.

Little Effect

However, the knowledge that a student had (or had not) been exposed to alcohol education was not, in this sample of college freshmen, of use in predicting either attitudes toward or use of beverage alcohol. Nor was the knowledge that a student had been exposed to church or school alcohol education found useful in predicting the accuracy of student information about alcohol.

There is no simple explanation of why the previous exposure of certain students to church or school alcohol education is not reflected in significantly different attitudes toward or practices with beverage alcohol compared with those of students not so exposed. One possible answer is that alcohol education does in fact take place outside church and school as well as inside.

It is relevant to note that, when asked to identify the persons from whom the most important information about alcohol had been learned, students most frequently reported "parents". The next most commonly reported source of information was the students' age peers.

Here again we are reminded that attitudes toward and used of beverage alcohol are the products of group experience. Courses in alcohol education in church or public school do not take place in a vacuum but in the midst of communities in which family and peer groups' experiences typically take precedence over classroom experience if a choice has to be made.

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A.R.F. ACTIVITY NEWS

APRIL 1959

Washington Backs Language Study

The U.S. government is providing $66,000 for a special five-year international study of classification and nomenclature in the alcohol field. The funds to be invested in this basic aspect of alcoholism research come from the National Institute of Mental Health of the U.S. Federal Department of Health, Education and Welfare and will be administered by the North American Association of Alcoholism Programs. NAAAP's Commission on Nomenclature, of which A.R.F. Research Director John R. Seeley is Chairman, will conduct the study.

Hamilton Sets Up Dundurn Clinic

The Hamilton Branch of the A.R.F. has taken over a building at 201 James St. South, just one block south of the Medical Arts Building. The new headquarters is within walking distance of St. Joseph's Hospital and other treatment services, which will help greatly with the planned program of intensive medical investigation.

An outpatient treatment and research program is being established under the name of Dundurn Clinic. The name "Dundurn" has long been associated with Hamilton and was chosen by the Hamilton A.R.F. Trustees to further public identification of the clinic with the city. Hamilton city council is this year contributing $25,000 toward operation of the new centre.

Reappoint Education Director

Robert R. Robinson, first Director of Education of the Alcoholism Research Foundation, has returned to the Foundation staff after an interval of 1½ years in industry. He resumes his post at the head of the Education Department. Vernon Lang remains with him as Information Officer, while William J. Wacko, who had been Chief of Special Education Services, becomes Assistant Executive Director of the Foundation as a whole. Among other things Mr. Wacko will be specifically responsible for activities of A.R.F. branches and for personnel administration.

New Research Posts

Beginning in July, there will be two Assistant Research Directors on the Foundation staff, one for biological sciences and one for social sciences. Dr. Harold Kalant has been appointed to the biological sciences position and Mr. Robert E. Popham will fill the social science position on his return from his present exchange assignment in Finland.

Dr. Kalant will divide his time between the Foundation and the University of Toronto Department of Pharmacology. At present he is head of the biochemistry section of the Defence Research Medical Laboratories, Toronto. Dr. Kalant is both a medical doctor and a Ph.D. in pathological chemistry and has had wide experience in medical and biochemical research in Canada, Britain and Chile. He was also at one time a part-time attending physician at Shadowbrook Hospital and Bell Clinic.

Mr. Reginald Smart has been appointed to the position of Senior Research Assistant.

Blueprint New Clinic Plan

Plans for a decade of expansion of the Alcoholism Research Foundation were announced in the Foundation's Eighth Annual Report, recently tabled in the Legislature by the Hon. Dr. Mackinnon Phillips, Provincial Secretary.

The Foundation currently operates one small in-patient unit in Toronto, and out-patient facilities in Toronto, London, Ottawa and Hamilton. Proposed new central facilities include:

(a) facilities for detoxication treatment of acutely ill patients within the Foundation as well as in community general hospitals,

(b) an adjacent rehabilitation unit similar to the present Toronto in-patient service at Brookside Clinic,

(c) an out-patient clinic with considerably expanded facilities for group and recreational activities and such specialized services as psychotherapy, casework, arts and crafts, reading rooms and a clinical laboratory,

(d) a specially equipped separate medical research unit,

(e) a 'half-way house' where out-patients might live while starting their rehabilitation in the community,

(f) a chronic treatment unit capable of handling patients who might be sent to it by the courts under any existing or future legislation in dealing with compulsory treatment,

(g) expanded facilities to enable handling of greater numbers of doctors, psychologists, social workers, nurses and so on who can receive training and professional education through the Foundation.

Resignations

Mr. W. F. Prendergast, Assistant to the President, Imperial Oil Limited, has recently resigned from membership on the Foundation's central Board of Trustees and Dr. W. Hurst Brown, Physician-in-Chief of Toronto Western Hospital, has resigned from the Medical Advisory Board. Also, Dr. J. P. S. Cathcart, who has resigned as Chairman of the Ottawa Branch Medical Advisory Committee, has therefore left the central Medical Advisory Board.

New Board Appointments

The Hamilton Branch Board of Trustees has added the following members: Mr. A. K. Moore, Superintendent, Open Hearth Department, Steel Co. of Canada Limited; Miss Alma Elizabeth Reid, Director, School of Nursing, McMaster University; and Dr. H. R. Elliott, President-elect, Hamilton Academy of Medicine.

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National Industrial Conference Board Reviews Problem of Alcoholic Worker

The following is reprinted by permission of the National Industrial Conference Board from its recent report "The Alcoholic Worker" (Studies in Personnel Policy No. 166), mainly from one of its five chapters. The complete report is available from the Conference Board, 506 Dorchester St. W., Montreal 1, at $2 per copy to Associates of the Conference, educational and government bodies or at $10 per copy to others.

NO ONE knows for sure just how prevalent alcoholism is in American and Canadian companies. Various surveys have been made, but none could be called scientific. Estimates of the numbers of alcoholics in a company have been made by top executives, by medical directors, and by personnel administrators. If a single figure is desired, it may be said that the estimates usually are close to 1%.

No company known to The Conference Board has ever admitted having *more* than 1% of its employees under treatment for drinking at one time, and usually the number given has been less than 1% of the payroll. But company representatives interviewed by The Conference Board frequently make the point that the number under treatment fails to give a fair picture of the true dimensions of the problem. They explain by mentioning two things: (1) that limited personnel and resources make it impossible for them to help all known cases, and (2) that probably a sizable number of cases are not being brought to management's attention.

It has been estimated that there are two million gainfully employed problem drinkers, and this figure has appeared frequently in writings on the subject. No one today can prove the estimate true or untrue. If it is even close to being accurate, then the 1% figure, of course, is much too low.[1]

Traditionally, industry has done little about alcoholism. Companies have attempted to keep alcoholics off their payrolls, or to discourage employees found to be problem drinkers. But they are discovering that it is not always easy to keep alcoholics off their payrolls, and that it's not always good practice to

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[1]*EDITOR'S NOTE: Two million is 3.3 percent of 60 million workers in the U.S. A survey of the prevalence of problem drinking in a representative Ontario county by R. J. Gibbins of the Alcoholism Research Foundation places the estimate closer to six percent of the working population. Whatever the precise figure in different parts of the U.S. and Canada, there is general agreement that "the alcohol problem" is a real and serious one for industrial management.*

discharge employees who become alcoholics. Also, an increasing number of executives now seem to be seeking constructive ways of dealing with the problem.

Those who have studied the subject speak of five things that management could do to help.

1. Establish and maintain a good "climate" within the company
2. Identify employees who are problem drinkers
3. Refer these employees to those who can help them
4. Support community centers that work with alcoholics
5. Support research in the field of alcoholism

The Right Company Climate

This subject has been discussed frequently in management circles and no lengthy review is needed here. By "the right company climate" people mean an atmosphere that makes for efficient conduct of the business, and personal development of the workers. As components of the latter, such things as the following might be mentioned: merit selection; careful job placement; full training; continuous communication so that everyone is kept informed of things that he needs to know; efficient organization structure; a sound philosophy of management; equitable compensation; promotion from within whenever possible; and high-caliber supervision. When these things are present in a company when they operate as a matter of course, the employees get the feeling that management is interested in them and in their wellbeing. Employees with problems, including drinking problems, have confidence that they can go to management and that they will be given a fair and sympathetic hearing. Their behavior may not be condoned, and they may end up losing their jobs; but they know that their problem will be understood, and that they will be given any help possible by the company to work things out along constructive lines.

The matter of company climate may be viewed from the opposite angle. A company president might ask: "Are we doing anything, or failing to do anything, which literally is driving our people to drink?" If illustrations are desired, they are not hard to find. Here are a few situations which exist in some companies and which tend to make some employees tense, confused, anxious, frustrated, hostile — and alcoholic:

- Lack of clearly-stated company policies and procedures
- Warring departments or key individuals at odds with one another
- Vacillation on the part of management
- Multiple bossism (when an individual is given orders, sometimes conflicting, by two or more superiors)

- Criticisms made in public
- Displays of favoritism
- Accountability and responsibility without commensurate authority
- Arbitrary decisions affecting the individual
- Incompetent, untrained supervisors
- Political promotions
- Gross inequities in compensation
- Inattention to grievances, real or fancied

Contrariwise, all the things that cause a company to become known as "a good place to work," help to develop positive attitudes in employees—and to lessen the need for escape through drinking.

Identification of Problem Cases

Asked what companies could do to assist his work, the director of a community center for alcoholics in New England replied simply, "Refer cases to us." Industry is not expected to provide a full-blown program for the rehabilitation of alcoholics (or for other sick employees), but it can help by identifying those that need attention, and by encouraging them to take advantage of the resources and facilities offered by the community. The identification of early cases, of course, offers the most promise for all concerned.

Several things are needed if a company is to do a good job of identification. A statement that all illnesses, including alcoholism, should be brought promptly to the attention of the company's medical department tells everyone that the problem is not one to sweep under the rug and forget, but one to bring out in the open and deal with forthrightly. The subject of alcoholism may be included in supervisory training programs. It may be mentioned in the company handbook and in the employee publication from time to time.

It is only a step—but an important one—from identification to referral. It seldom is an easy matter to get an alcoholic to recognize his need for help and to accept help. This is especially true of the individual in the early stages of alcoholism. "Referral" may mean insistence on attending A.A. meetings, on visiting a community center for alcoholics, on following a doctor's recommendations, on undergoing a period of hospitalization, etc.

The employee must understand that the company means business. The company is in a position to enforce its recommendations, and the employee knows this. There is no reason why management should not apply pressure judiciously. The company doctor or the personnel director is usually the one charged

with the responsibility of talking with the alcoholic employee, explaining "next steps," and of persuading the employee of the need to follow through.

A man's job is important to him for many reasons, of which money is only one. The threat of losing his job, especially if it's one he has held for some years and which has given him a measure of status among other workers, is a threat he is apt to take seriously. *It may be noted at this point that industry holds such a powerful hand in dealing with alcoholics that its cooperation is all but essential to successful rehabilitation work in a large majority of cases.*

Support of Community Services and Research

Alcoholism is not a popular cause today, and it may not be tomorrow. Whereas tuberculosis has its Christmas seals; infantile paralysis, its March of Dimes; etc., alcoholism often makes a negative appeal to the public. Many do not appreciate being reminded of the subject or being invited to contribute to the cause.

Treating a problem drinker is relatively inexpensive. Few alcoholics who are able to work require hospitalization. It has been estimated that the cost of rehabilitating the average alcoholic is no more than the cost of an office typewriter. The group that has been most successful in helping alcoholics—Alcoholics Anonymous — is self-supporting, and services are extended willingly without thought of compensation.

In the absence of community facilities, some companies have pioneered in this field and attempted to treat alcoholics. They have even provided help to individuals and groups outside their organizations. Others may wish to follow their lead, but it would seem that most companies would welcome a community-wide approach to the problem.

The companies that have established independent programs testify that these have more than paid for themselves—and proved themselves in nonmaterial ways as well. Thus, the cooperative approach might produce even higher dividends.

Some of the companies, of course, have gone further than others. No two programs are alike. But some experiences were reported to the National Industrial Conference Board by all or by a majority of the companies which took part in the Conference Board's recent survey. These common findings may be noted here.

- It is salutary to get the problem of drinking out in the open
- A positive program does not involve coddling those in need of help

- The individual who does not wish to be helped may have to be discharged
- It is important to train managers and supervisors to recognize signs of alcoholism in their workers
- Referral of early cases is preferred to referral of advanced cases
- This is an area where the union and management can work together effectively
- The costs of a program are nominal; they may be less than the direct savings
- More than one-half of those wishing help can be helped
- An employer is in a particularly strategic position to deal with an employee who is drinking too much and who knows that he may lose his job if he persists in his course

Proper research into the causes of alcoholism and into various treatment methods cannot be carried on inexpensively. Some of this work can be supported by public funds, but industry undoubtedly will be asked to contribute directly, too. And it can be assumed that industry *will* contribute as it comes to understand the toll that alcoholism exacts in human misery, as well as in business profits.

Role of Medical Department

Companies with staff doctors or with doctors on call are likely to turn to them for help and guidance in cases of alcoholism among employees or managers. While it probably is true that a majority of industrial physicians are more interested in other types of patients, they nevertheless may be expected to do what they can for the alcoholic.

In general, they will *examine* and refer. *They will examine the worker* to see if he *is* an alcoholic. They may carry the diagnosis further and try to determine what *kind* of alcoholic he is. (If the prognosis is good, the company may go to greater lengths to help rehabilitate the individual than it would in the face of an unfavorable prognosis.)

Few companies offer employees direct medical treatment, feeling this to be outside their province. They rely on doctors and agencies in the community for therapy. But the company physician probably knows what resources are available. In a community that is well equipped to help an alcoholic, the medical director may refer him to:

- An alcoholic information center
- An out-patient clinic, a hospital, or a sanitarium
- A family service agency
- A visiting nursing service
- Alcoholics Anonymous
- A doctor (general practitioner or psychiatrist) who is interested in problems of alcoholism
- A religious counselor

Explore Why A.A. Works and for Whom*

In the treatment of many illnesses, such as heart and mental disease, methods that go beyond the purely clinical and extend into the everyday life of the patient are essential. This type of constant therapeutic influence is particularly necessary for alcoholic patients. In this context, the work of Alcoholics Anonymous has demonstrated the enormous treatment potential made available when groups of patients assume responsibilities for their own recovery.

Alcoholics Anonymous is a loosely knit association of many small groups, varying from five or six to a hundred alcoholics who are trying to discover for themselves how to live without alcohol. The only requirement for membership is that the individual be an alcoholic.

There are no dues. Collections are taken up to pay the rent for a meeting-room or to maintain a central office, but members are not forced to contribute. Usually the only office is the chairmanship of a local group, and this is a rotating office. A group meets once or twice a week, and every month or so holds a meeting that is open to the public. Some groups own elaborate clubhouses; some meet in the homes of the members.

The active members in A.A. are primarily men between 30 and 60 years old but recently there has been a marked increase in the number of women and of young men under 30. They represent all occupations and economic classes, all degrees of education, and diverse religious and political affiliations.

A typical open meeting begins with a talk by the chairman who outlines the purpose and character of the fellowship. Five or six members will then explain how they became alcoholics; how they got into A.A.; and what A.A. has done for them. Some of the speakers are inspirational; some try to analyze reasons why people become alcoholics; some explain the Twelve Steps of A.A. Occasionally an outsider who has some relevant knowledge will give a talk. The meeting closes with The Lord's Prayer. There are usually periods of "coffee-clatching" before and after the speeches. Closed meetings are less formal.

A.A.'s generally try to help other alcoholics only when they ask for help. They try to persuade these alcoholics to come to meetings;

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help them recover from bouts; encourage them to eat and to seek medical treatment; talk with them; and help them to find jobs. The prospective member is not taxed with his shortcomings; he is only asked to give up alcohol for the next 24 hours. He is reassured that he is helpless, as are all alcoholics. He is told not to be too worried about all of the Twelve Steps. He is urged to call one of the members if he feels that he must have a drink.

He may be given or lent a copy of the book, *Alcoholics Anonymous,* which explains the movement, the Steps, the groups, and gives a series of brief successful A.A. histories. One member becomes his particular sponsor. Eventually, he will be trying to help another alcoholic and thus become a sponsor himself. Anonymity is maintained to protect the members.

The Twelve Steps

The common denominator that binds together the widespread, loosely organized, variously composed A.A. groups is the set of Twelve Steps recorded by the original founders as guideposts for the restoration of the alcoholic:

"1. We admitted we were powerless over alcohol — that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being, the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people whenever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs."

In discussing the way in which this type of therapy works, S. D. Bacon (Yale University) calls it a resocialization process that weans the individual back into the society

from which he has been isolated by the effects of alcohol. For this purpose the flexible, accepting structure of A.A. is most effective as it has scope for the alcoholic in all stages of what is actually a maturing process: from his initial parasitic role while he is still dependant on his sponsor; through the active-member role when he becomes a sponsor himself; to the active-member-plus-idea role when he begins to gain real understanding of the meaning of the A.A. program. This process gives the alcoholic a chance to activate needs for dominance, importance and self-expression through useful, socially constructive channels in the fellowship.

H. M. Trice (Cornell University) explains the effectiveness of A.A. in terms of the new self-concept it gives to its members. The new member gains in self-respect from the realization that his problem is due to illness rather than lack of willpower. His relation to the A.A. group gives him a new sense of belongingness. And this feeling for the group and his part in it is strengthened by his sharing of obligations, aims and emotional problems with other members in an informal atmosphere.

According to Trice, the more outgoing, sociable individual who can share basic emotional reactions with others, who can adapt easily to the casual give and take during meetings, and who has had some experience with small informal groups, is most likely to be attracted to A.A. and to stay with it. Other alcoholics may try A.A. but fail. These include, for example, persons whose emotional rewards from heavy drinking still outweigh their emotional discomfort; those who feel little conflict about their drinking; those whose drinking is supported by a well-defined approving group; and those whose families unconsciously support their drinking by covering up or by trying to solve their problems for them. Alcoholics who initially reject A.A., however, may return to it when intensified troubles bring them to a state of desperation.

Trice points out that the Twelve Steps create attitudes that are psychologically therapeutic. Step 1, for example, "relieves the alcoholic of the need to demonstrate that he can drink like others." Steps 2 and 3 "enable the alcoholic to realize that . . . he needs help from outside himself." Step 5 helps to reduce anxiety by the sharing of emotional problems, and Step 8 helps to reduce guilt through restitution.

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This periodical is published four times a year in the interests of a deeper understanding of the widespread disorder alcoholism.

Each issue contains pertinent, factual information selected primarily because of its interest to those who are called upon to deal with alcoholism professionally. Articles published do not necessarily represent the views of the Foundation.

If you would like to receive this publication regularly, or if you wish additional information about some aspect of alcoholism, you are invited to write to the Alcoholism Research Foundation, 9 Bedford Road, Toronto 5, Ontario (WA. 3-2474) There are also branch offices at:

201 James St. South, Hamilton (JA. 7-4941)
481 Queens Ave., London (HU. 7-7434)
1206 Bank St., Ottawa (CE. 6-9717)

Circulation of this issue: 10,0

Vol. 6, No. 2
July, 1959

alcoholism
RESEARCH
TREATMENT
EDUCATION

Toward Effective Alcohol Education

*By Robert R. Robinson**

DRINKERS and non-drinkers disagree violently on many points, but there is at least one relevant issue upon which they are in complete agreement: both are opposed to alcoholism and would like to see this problem materially reduced. There is disagreement over the best means of achieving this, but no disagreement as to the desirability of the end result. It is worth noting, by the way, that drinkers and non-drinkers disagree even among themselves as to the preferred ways and means.

Some invoke prohibitory legislation, others favor a process of education; and there is a vast variety in their recommendations regarding the nature, content and duration of education, both in the school system and outside it, with respect to alcohol, drinking, intoxication, and alcoholism. Usually, however, even the advocates of outright prohibition will acknowledge that there is a place for education — as well as for legislation.

**Mr. Robinson, who became Education Director of the Alcoholism Research Foundation in 1953 has returned to the Foundation staff after a 1½ year interval of employment in industry.*

What, then, can be taught about alcoholism and its origins that will be of benefit both to those who drink and to those who do not, and which will work generally in the direction of reducing this disorder which is becoming increasingly prevalent in our society?

A Source of Facts

Over the 10 years since the Alcoholism Research Foundation was established in Toronto, its professional treatment and research workers have drawn together a substantial body of knowledge, some of which can be effectively and beneficially transmitted to various groups and levels among the public, to men and women, to teenagers, to drinkers, to alcoholics and to non-alcoholics.

A logical starting point might seem to be the dimensions of the area under discussion — the proportion of abstainers (approximately one-third of the adult population) and users of alcoholic beverages; the prevalence of alcoholism (something like 70,000 Ontario residents); the incidence of alcoholism (about 4,000 new cases per year). More provocative however, would be something closer to the practical, personal interest of people who themselves drink socially or who see social drinking going on around them.

As a matter of fact, one could do worse than start with a question posed in the Ontario course of study for Grade XII physical education: "What does alcohol mean to the young adult?" Such a question opens the way for consideration of the role played by alcoholic beverages in various parts of our society (and comparatively in other societies and in other time), and for a recognition of the symbolic values attached to drinking. Drinking and intoxication do play significant roles in our society and to fail or to refuse to recognize this is to take on an unnecessary handicap in discussing the subject.

Important Points

Other aspects of the subject are also important, of course — what kinds of beverages people drink, what happens to alcohol in the body and to the body with alcohol in it, how various quantities of alcohol affect the judgment, muscular coordination, and behavior, what is the pattern of drinking that leads into alcoholism and what are the recognizable stages in its development, what can be done to arrest the progressive deterioration of alcoholism and to assist in the patient's rehabilitation . . . The dissemination of such information serves a useful purpose to individuals who drink, to those who do not, and to society as a whole. It is particularly valuable to young people at the time they are beginning to encounter social situations where they may be exposed to social

drinking. They urgently need dependable information and an awareness of the many factors involved.

(This need for knowledge may not have the same urgency among all parts of the teen-age population, of course. Young people from homes and social groups where total abstinence is accepted and practiced, and where parents are held in respect, may not have any serious questions in their minds about it. They see drinking depicted in the movies and TV, they read about it, and see advertisements in the magazines; but the real people around them and upon whom they are modelling their grown-up behavior don't drink, so in most such cases the younger people are not likely to do so either — at least while they remain a part of their original social group.

Keep Perspective

Need for knowledge of this kind is, however, very real for all young people, just as real as the need for many other kinds of knowledge which may later inform their behavior and contribute to their understanding of themselves and of those around them. And this is a very important point — that a disproportionate emphasis should not be placed upon the study of alcohol and its effects, nor should alcoholism be made to look too large in relation to other social problems. Its real size is quite sufficient without distorting it to bogeyman proportions! The key to understanding alcoholism, as a matter of fact, is precisely this: to see it in relation to all of life and to all of life's problems, and not to view it only darkly through a bottle.

Alcoholism's Roots

Alcoholism might be said to have three roots — alcohol itself, which by definition must play a part; the make-up of the individual who has learned to be dependent upon the effects of alcohol; and the social context in which that individual is attempting to live and to achieve some degree of satisfaction. To approach this inter-acting complex through only one of these factors is to make an understanding of alcoholism impossible.

Handled with wisdom and in the light of established facts, a study of alcoholism can be a most enlightening experience for people of any age or station. Few persons from school age up have no knowledge or experience of a relative, friend, neighbor, or business acquaintance "who drinks too much for his own good" — or who used to do so. In ignorance or in prejudice, such "victims of alcohol" are frequently dismissed with a shake of the head or a shrug and the comment that, after all, "he brought it on himself". Looked at in the light of present knowledge the alco-

holic presents a much different picture; and he or she may reflect an unexpected (and not altogether comforting) image of the society in which we live and to which we contribute some characteristics.

Value of Discussion

If it is a function of the school system to assist in the preparation of young people for effective, satisfying living, then a discussion of some aspects of alcoholism would seem to present teachers with a real opportunity for instruction. With the principal focus on alcoholism rather than upon the vexed and vexing wet-dry controversy, light rather than heat can be generated in all parts of the class — and, in many instances, at home among parents.

Teachers have traditionally been afraid of anything but the most superficial — and therefore misleading — treatment of this subject. And even among the few Ontario teachers who touch "alcohol studies" at all, only the smallest minority have enough confidence and information to permit free classroom discussion of drinking and its implications. Yet, it is the experience of Alcoholism Research Foundation staff that whenever they meet with a group of teenagers there ensues a most stimulating and enlightening discussion. Young people are eager to learn about all aspects of growing up: and, from their observations of the adult society into which they are emerging, the use of alcoholic beverages is significant. They are seriously interested and anxious to discuss the subject, a situation which must be made to order for any teacher worth his salt!

It only remains, therefore, to provide a means for teachers in Ontario secondary schools to gain the information and confidence they need if they are to grasp this opportunity for helping young people to learn about alcoholism — and, through discussion of alcoholism, about many aspects of life. The Alcoholism Research Foundation is regarded by the Ontario Department of Education as a dependable, official source of data on the subject; and the Foundation, for its part, stands ready to put its accumulation of knowledge and experience at the disposal of teachers and others in a position to take on a share of this important responsibility to our citizens of tomorrow.

Doctor Views Drugs in Perspective As Part of Alcoholism Treatment

*By J. D. Armstrong, M.D.**

IN THE history of medicine those highlights which have caught the public's interest have usually been discoveries of new drugs or vaccines which dramatically changed traditional ways of treating or preventing certain dreaded illnesses. Quite naturally, therefore, many people think or hope that for almost anything labelled as an illness the physicians will produce some mysteriously miraculous substance to put in pills or in their needles.

With alcoholism there is a certain amount of similar wishful thinking. Perhaps it is not in vain to hope for some substance of dramatic importance to alcoholism treatment in the future, but right now we have alcoholics needing to be treated by whatever methods are already on hand to use. Though in a sense one of the roots of the illness comes packaged in a bottle, the treatment does not have the same simplicity. The chemicals that can be used are many and varied but their roles are strictly those of adjuncts to the general medical, psychiatric and social management of the alcoholic.

There has been considerable publicity on the discovery and the use of what are known as protective drugs, developed specifically for treatment of alcoholism. We now have two such drugs available in Canada for use on physicians' prescription only: disulfiram, (sold under the trade name Antabuse) and citrated calcium carbimide (sold under the trade name Temposil). The first, disulfiram, was developed by the Danish Workers Hald, Jacobson and Larsen some ten years ago[1]; the second, citrated calcium carbimide, (known for short as CCC) was developed by Doctor J. K. W. Ferguson[2] of Toronto under a series of grants from the Alcoholism Research Foundation beginning in 1953.

Not "Cures"

Neither of these can be regarded as a "cure" for alcoholism. Recovery from alcoholism still requires learning to get along comfortably without the use of any beverage alcohol. Such a process is, to the alcoholic, not nearly as easy as it sounds to the non-alcoholic. The two drugs mentioned can both help alcoholic patients on the road to permanent sobriety, provided

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**Dr. Armstrong is Medical Director of the Alcoholism Research Foundation.*

that other treatment methods (and possibly other drugs as well) are also being used appropriately to each particular case.

Chemical "Fences"

Disulfiram and CCC have been described as "chemical fences" between the alcoholic and the drink he needs to stay away from. Taking the pills does nothing to the patient; taking a drink with the drugs still in one's system produces a sudden state of unpleasant physical illness: the knowledge that this might occur is what actually functions as a fence for the recovering alcoholic. The only value the drugs have is as a result of this knowledge the patient has of their action. Instead of having to decide half a dozen times daily whether to take a drink or not, he only has to decide once or twice each day to take his pill. The diminished need to make the decision regarding drinking (an important decision to the alcoholic) in itself reduces anxiety; and anxiety in itself may influence a decision in favour of drinking since the sedative action of alcohol readily reduces anxiety.

Meanwhile, by other means, the patient should be building up the physical and psychological defences against and substitutes for his pathological desire to drink: but even if he should succumb to this desire despite the presence of a protective drug, the reaction makes it impossible for him to go beyond that first drink which might otherwise precipitate a prolonged bout.

At least three conditions must exist before beginning a course of treatment involving use of protective drugs:

1. The patient must have consumed no alcohol for a period of twelve to fourteen hours prior to the first dose of drug.
2. The patient should be free of advanced cardiac disease or any gross degree of debility in which he could not tolerate a sudden major demand on the cardiovascular mechanisms.
3. The patient must *want* to stop drinking completely, not merely to moderate his drinking, the latter being something which, as far as we know, a true alcoholic simply cannot do.

Aids to Detoxication

While detoxication can be brought about simply by somehow depriving the patient of beverage alcohol for a sufficient length of time, the time can be shortened, and complications avoided by the use of various medications. A great variety of drugs have been found useful to the alcoholic at the acute stage, but they have now been largely superseded by the newer tranquilizing drugs. Such drugs as chlorpromazine, promazine hydrochloride, perphenazine, reserpine and possibly meprobamate, not only give the patient a sense of comfort

that enables him to sleep but also relieve his nausea so that he can eat much sooner than was the case with earlier treatment. Of the tranquilizers listed, perphenazine, may be the most satisfactory yet. It is given intra-muscularly at first, and later orally.[3]

Nutrition

Detoxication is normally combined with various measures to restore the patient to an adequate state of nutrition. While some theories have been advanced as to the preventive effect on alcoholism of certain types of diet, the evidence so far produced for this has not been too convincing. Excessive drinking and poor diet go together, but the effect of drinking on eating practices seems much more obvious and clear than any effects that any particular diet might have on the compulsion to drink. However, there is no doubt that several of the more serious complications of chronic alcoholism stem as much from malnutrition as from drinking. Rapid improvement in diet can therefore do much to help prevent such complications. At the same time, it should promote a feeling of general well-being that can help the patient accept subsequent efforts to prevent reversion to alcohol.

On emerging from the detoxication phase of treatment, a significant number of patients (but by no means the majority) may need some continuing medication apart from diet. Vitamin and mineral preparations may be used as diet supplements, although their precise value is none too clear. In addition continuation of some tranquilizing drugs may be helpful for a few days.

There is always the risk of simply shifting the addictive behavious from one chemical, alcohol, to some other, which may produce more serious habituation. Barbiturates, bromides, paraldehyde and some of the milder sedatives are dangerous in this way; even the use of tranquilizers should be very carefully controlled by a physician. With most patients such medication should be discontinued within a week or so, and except for the rare exception, before the patient leaves hospital.

The occasional patient requires recurring drug support at some subseqeunt time of crisis. By this time though, psychiatric, social, and various re-educational techniques and therapies should be becoming established as the focus of treatment. The voluntary introduction to a protective drug can then be tried in order to help give the overall treatment program a stretch of time to take effect.

Comparisons

Of the two protective drugs, disulfiram and CCC, the latter was until recently available only on special order for clinical trials which were taking place at Brookside Clinic, the Bell Clinic, Alex G.

Brown Clinic, and various centres outside Toronto. However, early in 1959 it was released to pharmacists in Canada, so that any physician can now prescribe either drug. The basic differences between the two can be seen from the following table.

TABLE I

	Daily Dose	Sensitizing Time	Protection Time	Intensity of Protection	Side Effects
Disulfiram	500 mg. 1 tab	Slow 7-10 days	Long 7-10 days	Violent	Frequent fatigue; rash, odour, taste, impotence.
CCC	100 mg. 2 tab	Rapid 2-3 hours	Short 2-3 days	Mild	Almost none

In making a decision as to which drug to use, one weighs a variety of factors. There is no question, of course, that if a patient has been on disulfiram and has experienced some of the unpleasant side effects, the use of CCC is indicated. On the other hand, there is a substantial group of patients who at this stage in their recovery still lean to extremes and gain a greater sense of security knowing they are taking a drug which provides them with greater assurance of a severe reaction. For other patients, who approach all of their problems with anxiety, it is of some assurance to be able to present them with a drug which appears to have little danger about it and yet has sufficient likelihood of making drinking unpleasant enough to dissuade the user from beginning another bout.

In treating a severe reaction to disulfiram, simple measures for support of shock are the most adequate way of dealing with the situation—oxygen, intravenous glucose, cardiac stimulants, foot elevation, etc. As a matter of fact, one has the further impression that these are usually unnecessary gestures, in that the peak of the reaction has generally passed by the time medical aid reaches the patient.

When disulfiram was first introduced, it used to be common to administer the drug for 3-4 days and then give the patient a trial dose of alcohol so that he might experience the reaction. This testing procedure has now been abandoned in many centres. Brookside Clinic has never used the test reaction routine but has relied entirely on giving the patient verbally a thorough understanding of the expected reaction.

Conditioned Reflex

There is one other older and rather rarely used drug therapy that is carried out in some places (although not routinely in any Canadian clinics) and that is known as conditioned reflex treatment.[4] It involves giving a dose of a drug such

as apomorphine, to produce emesis at almost precisely the moment when the patient takes a drink of beverage alcohol. Repeated administration results in the association of vomiting with drinking and eventually a revulsion to any thought of drinking which may last for several months.

This treatment method is used in some European and American centres. Generally speaking, it works best on patients whose motivation toward stopping drinking is quite high. It also requires very precise timing and careful control of environment. In recent years very few clinics have felt it worth while to emphasize this conditioned reflex type of treatment. The results do not seem to be any better or more permanent than those from the less unpleasant therapies now being generally used.

While certain European and British specialists claim that apomorphine has certain distinguishing values with alcoholism which make it useful quite apart from the use as a drug for continued reflex therapy, this is not widely accepted by scientists in the field.

Hallucinogenics

Recently investigators in Saskatchewan working with LSD-25 (d-lysergic acid diethylamide) have suggested that this drug produces an emotional experience in the alcoholic of such a profound nature that he may re-orient his approach to his personal life and problems. This method is being explored now in many centres and may hold some promise for management of certain cases.[5]

In summary it may be said that for every stage in the treatment of alcoholism there are drugs available to help the medical practitioner deal with alcoholic patients. Such drug serve a variety of purposes. They play an important part in treatment; but so far it is definitely only a part of a more complex process involving many techniques, some of which are medical and some not. Furthermore, existing drug therapies all involve products that can only be safely used under medical supervision — the possibility of finding some common drugstore panacea that anyone can use to stop alcoholism is still a long way off.

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Clergymen Can Help Alcoholics Start On Road To Recovery

*By Rev. John A. McGonegal, Anglican Chaplain, Verdun Protestant Mental Hospital**

IF YOU are a clergyman people come to you for counselling on personal problems. Many whose personal problems are with alcohol will at first ostensibly come to discuss some altogether different matter. This is because of their fear that their pastor will condemn them for drinking or drunkenness.

The alcoholic needs to test your attitudes about drinking, to find out if it is safe to talk about his drinking problems. Until he has made sure of this he is going to talk about something else. In practice he can do so by discussing some real problem, which may or may not be connected with drinking. In describing some details of this problem he will make some slight reference to drinking. Only if you do not get too upset by this testing of your attitudes will you really grasp what he is trying to talk about.

To test you further he may start drinking and then call you in. He has to see if you really can accept him when he is drinking. Only when he becomes certain that he is accepted will he feel free to talk to you about his drinking problem as such.

If and when the person himself admits that his own drinking is troubling him you will need to assess how strongly he is motivated to do something about it. You can elicit some idea of this by simply asking, "Would you like to be able to stop drinking?" If his answer is a fairly clear-cut "Yes," then the stage is set for discussion of the kinds of help he could use and the resources that are available.

Long Process

Such a stage of readiness is only rarely reached as soon as you would like. As with all counselling, the initial interview must be viewed on a long term basis. The visits are likely to be spaced out spasmodically over a year or two with periodic interruption by his need to test your attitudes. Even if your visitor obviously drinks to excess, do not make the mis-

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**Prior to taking this position Rev. John A. McGonegal was for 3½ years the pastoral counsellor of The Alcoholism Foundation, Toronto.*

take of taking over the doctor's job: the doctor who diagnosed him as an 'alcoholic' probably would not say so to a patient right away. The task you face is to help the alcoholic assess his own problem, not to stick labels on him.

Sometimes you may decide to ask your visitor to clarify some reference he has made to drinking. It is very important here to let him volunteer his own information. If your judgment was right he may feel encouraged to open up further on the subject. If you were wrong it could be in one of two ways: either you misread the signs of a problem with alcohol; or else he may not be ready to accept his problem. If you were wrong, you will have to back away as gracefully as you can from the subject and outwardly at least accept the person's assessment in order to maintain the counselling relationship with him.

Learn Own Limits

It is very important to know the limitations of your counselling skill with the alcoholic. This is nothing to be ashamed of: every counsellor has his own limitations and every good counsellor knows them well. In any community you can count the number of competent counsellors on fingers of one hand. They have several years of experience. Unlike the average pastor with his great variety of work, the successful counsellor is a specialist.

Referrals

You will, therefore, want to get to know personally some people who are more expert than yourself and to know something of the help and services they offer to the alcoholic. It is a good idea to begin preparing, by the end of the first or second visit, for a possible referral. To say simply, "This problem is not very clear to us yet—we may have to get someone else to help us," can greatly relieve the person's anxiety. It shows him that you know your own limitations clearly and that you don't just grope along alone.

On the other hand, all of us are guilty at times of trying to make too hasty a referral. When the alcoholic who is drinking is acutely ill or very aggressive, it is necessary to get help for him quickly. Most times though, you can still communicate with him, if you take time and talk quietly. Try to prepare him for going to the hospital or clinic. Tell him where he is going. Take him yourself if you can but be sure that he himself realizes his need to go. Unless he is immediately in need of a doctor to save his life, he can still make this decision for himself. Frequently he will waver in his decision, but your own quiet manner is the best assurance to him at his point.

A successful referral in counselling is built on the strength of personal relationships — the strength of the alcoholic's relationship to you — the strength of your relationship to the person to whom you are referring him. He will need to use the strength of both relationships to complete a referral successfully.

When you have established a counselling with the alcoholic, then don't expect him to have the courage to go to a name or a street address or a voice on the end of a telephone. It took a lot of courage for him to get to you and its going to take just as much for him to leave. He needs to know a good deal about the person you are sending him to. You too will need to know this person pretty well so that you can let the alcoholic know the kind of person to expect and something of his qualifications to help. Get to know some interested local doctor; visit a nearby clinic or your local Alcoholics Anonymous group. It will help you to know these people better and to know something of the types of help they offer.

Alcoholics Anonymous

You will find that you are welcome in your local A.A. group. You don't have to be an alcoholic to associate yourself with A.A. One of their slogans is "Keep an Open Mind". They will be friendly to you if you do this. They want you to learn about their spiritual program and the way in which it is helping them to live a new life without alcohol.

Your association with an A.A. group can develop usefully in several directions. It will bring you into contact with people who are suffering with alcoholism and help you learn to understand them. There are many in A.A. who want to come into a church as well, but who know church people's difficulty in accepting the alcoholic. You can open a door for these people. Also, some A.A. member who is well established in the program may be able and willing to help you with the alcoholic in your church.

Clinics

Many alcoholics cannot respond without clinical help. There are alcoholic clinics in some cities. Family physicians refer patients to these clinics from several hundred miles away. If you are far from a clinic, sound out your local doctors and see which of them will refer an alcoholic to the nearest clinic for treatment.

During each initial counselling session you are studying three things:

(1) You will hear the alcoholic's own description of his problems.

(2) You will be listening for his feelings about how his problems relate to other people.

(3) You will want to know what he does about them.

From what you hear, you are going to be fitting together bits and pieces of information about his strengths and weaknesses. Before any referral is made, you will want to have an accurate picture of his real strengths to form a new relationship. The goal of all your work is for him to learn to do as much as he can for himself.

Fear Others' Attitudes

How do you know when the alcoholic is ready to use help? You need to know this, not only for his sake but your own. You are a busy person and there are so many other important functions in your ministry besides your pastoral work. You cannot give all your time to one or two alcoholics. In order to become more accurate in estimating his readiness to use help you will need to understand some of the more common personality traits of alcoholics and the ways in which you may find yourself reacting to them. The alcoholic has an inherent fear of the attitudes of other people towards his drinking. You can see an expression of this in A.A. in the saying, "Only an alcoholic can help an alcoholic". This is his defence against the misconceptions and prejudice that surrounds the use of alcohol in our society. We have all grown up to inherit some of these misconceptions and prejudices. It takes effort and willingness on our part to correct our own thinking and feeling about alcohol.

It is important to your pastoral work with people, to work out for yourself the meaning of drinking to you and to decide the place of alcohol in your life. If you are a non-drinker who is made anxious by the drinking of others so that you withdraw from them, then you are not going to be much help to the alcoholic. Nor will you help him much if you find that you can accept him because you take the occasional drink, but are made anxious by the attitudes of some non-drinkers. After all he is going to have to become a non-drinker himself to recover, and whether you like it or not, you are unconsciously going to indicate to him your attitudes toward non-drinkers. This can hardly help the alcoholic when he recovers, since it will eventually break down your relationship with him.

Immaturity

The second personality trait of the alcoholic that raises problems in counselling is his immaturity. Frequently when he is unable to accept responsibility he withdraws into his bizarre drinking. When he doesn't, he shows some other signs of his immaturity. He will com-

plain that it is hard to find a job. When you send him for one, he may not even go; or he goes and takes the job, only to quit at the end of the first week. He has not the capacity to accept adult responsibility. There may be many reasons for this in his childhood development, which you will learn about as you come to know him. All this knowledge about him will be of little use if you cannot accept his child-like behaviour for what it is and at the same time respect him as an adult.

Your capacity to accept his immature behaviour is going to depend a good deal on your own need to be successful with him. Success in terms of the praise of others, is possibly one of the most glaring signs of immaturity in our culture. It is not surprising then to find it in ourselves as well as the alcoholic. If your own success is more important to you than his, then his failures are going to make you upset and anxious. Doing something for a person without taking credit for it with others is an important part of the anonymity concept in A.A. Success for ourselves is something we must come to terms with in our ministry if we are to help the alcoholic.

The chief sign of his immaturity is his over-dependency. He has not learned the balance of dependency and responsibility in his relationship with people. When he first comes to know you he will want you to do everything for him. Yet basically he resents being dependent. He may enjoy being indulged by you for a time, but eventually he will leave you. If your own needs with people are to have them depend on you, you will have trouble with the alcoholic.

When you have found what he is able to do for himself, you are on the growing edge of his responsibility. Feed responsibility to him slowly, and try to control your own irritation when he is unable to carry it. Some of us shy away quickly from the person who is over-dependent. Yet an over-dose of independence can also frustrate the counselling relationship.

Hostility

The third personality trait of the alcoholic, which may cause difficulty for the pastor in counselling, is hostility. Not every alcoholic is openly hostile. Many only show it when they are drinking. There is however a basic hostility which is a reaction against fear and anxiety. If you have not learned to accept hostility from people without wanting to strike back verbally or retreat, you will find that your counselling relationship with the alcoholic will be easily disrupted.

By working with the alcoholic, you will learn to be understanding toward many of his minor personality traits: his need to alibi, or rationalize his drinking, his inability to keep appointments, his un-

truthfulness to you, rather than face a breakdown in your relationships. His impulsiveness, his criticism of others, his impatience, these and many more he will bring to the counselling relationship for you to understand.

Relatives & Employers

The alcoholic will often want you to help him restore relationships with his wife or his employer. Don't fall into his concept of your role. You can, however, explain your willingness to hear their side of the story and attempt to interpret to them his condition. Only when he agrees to this, however, are you free to be his interpreter.

Often these people are discouraged, because they have also been trying to help him. They will need some time to talk out their discouragement with you. If they do, then your way may be clear to act as interpreter. Avoid if possible making any arrangements or agreements for the alcoholic with his wife or employer. Allow him to make these for himself.

You will find that you will need to be firm at times in order to resist the alcoholic's efforts to make you the reconciler of his marriage especially when he has first stopped drinking. He needs a substantial period of sobriety, before his wife can regain her trust in him. I know that one of the pastor's jobs is to prepare people for marriage. Also, we do marry them. Remember, however, that the alcoholic's drinking is only one aspect of the disruptive forces in his marriage. It is not uncommon for the wife to need a good deal of help with some of her own basic attitudes and behaviour in the marriage before they can achieve adjustments. If you are aware of some of these disruptive forces, it may help you to be more understanding of the wife and family.

When the alcoholic who is living with his family stops drinking, there is sometimes an unconscious need of the family to make him start drinking again. His emotional problems and those of the family are still unresolved. When these tensions become acute, he may be forced into another drinking episode. The wife has made adjustments to the drinking behaviour and its consequences in her husband. She has had to take over her husband's role of father and sometimes provider to the children. It is understandable that she will not give up this role easily. Long ago she has learned to mistrust her husband's ability to control his drinking. She lives in fear of the disastrous consequences that come with each drinking episode. She has even made a defensive adjustment to her own shame. She is not going to relinquish a satisfactory adjustment to all this, until she has gained some confidence in his sobriety and his ability to take responsibility for providing for her and the children. When she begins to get some

positive satisfactions from his sobriety, her unconscious need to keep him drinking may decrease.

At some time you will be faced by a wife who says "Pastor, he won't listen to me. Will you go and talk to him about his drinking". I know there is a strong temptation to go, but this is not the solution to her problem. Her problem is that *she* cannot talk to her husband about his drinking. If you listen to her side of the problem, and give her some interpretation, then her controlling attitude toward his drinking may change. When she is able to stop nagging him about his drinking and tries to understand why he drinks, either the drinking problem will clear or the husband himself may seek help. Not all people who drink too much are alcoholics although they may have acute problems in their living.

Religious Needs

The alcoholic who comes to you, is not only interested in controlling his drinking; he has come to you because he wants a new way of life. In his religious life he is only ready to sip milk. He will be sickened if you try to feed him meat. He needs time to work at his religious life at his own speed. If he is attending A.A., and he knows you know something about it, he will sometimes come to you with his questions. The more familiar you are with A.A. language and its meaning in theology, the more ready you will be to answer his questions in a language he can understand.

Two Occasions

There are two occasions in his A.A. life when he may come to you. The first is in terms of his faith and commitment, in the second and third Steps of the Twelve Steps Program. He will be working through most of this in his own A.A. group but may ask for your interpretation in terms of his past religious training. He may also want your approval because he still respects the Church. Although the A.A. program is not in the language of theology, you need to understand it for yourself perhaps by participating in an A.A. group yourself for a while.

The second time when he may come to you is when he is working at his confession in the fourth to the ninth steps of the program. In this you may find yourself trying to transpose him to the custom of your church. You will be tempted to make great jumps of interpretation in your own familiar language. A great deal is going to depend on how strong your needs are to make things go your way. Be certain you are ministering to his needs and not to your own.

There may also be times when a church member who is an alcoholic comes to you to make a confession, or he may come asking to take a pledge not to drink. You are going to have to work out in your own thinking whether or not you make

a distinction between alcoholism and drunkenness. If you distinguish between the two you will not permit him to confess his drinking episodes or take pledges which he can't keep—these only increase his feelings of guilt and aggravate his drinking further. One of the alcoholic's chief difficulties is that he has loaded onto his drinking behaviour some guilt feelings which are more properly attached to other areas of his life. He will only begin to discover a new way of life when he looks behind the drinking episodes at the more serious disruptions in his relationships with people and can find and use the appropriate spiritual resources that are open to him.

Social Anthropology Is Useful Tool In Developing Alcoholism Research

Ontario Researcher In Finland Compares Scientific Approaches

*By Robert E. Popham**

MY PURPOSE in this paper is to indicate what seem to me to be the principal general differences in the research work of the Ontario Alcoholism Research Foundation and the Finnish Foundation for Alcohol Studies; also to outline briefly a few important problems for future investigation.

Perhaps the first difference which should be noted is that, generally speaking, the Ontario Foundation has tended to focus on alcoholism and the alcoholic, and the Finnish Foundation on alcohol consumption and drinking behaviour. This difference may be due in part to the closer and more continuous association of the research staff with a clinical facility in the case of the Ontario Foundation; or in part to a difference in what has been perceived, by members of the 'community' at large, as the problem of major importance: in Finland it has been "explosive intoxication" and in Canada, the social and personal consequences of alcoholism. But, whatever the reason, the difference may be considered to represent simply different starting points with similar ultimate ends in view.

The second difference seems to be reflected primarily in the research methodology of the two foundations, and to be a function of a difference in the social scientific tradition in which the research staff of each foundation works. In the case of the Finnish Foundation one might characterize the tradition as essentially sociological, and in the case of the Ontario Foundation as social-anthropological.

It is important to stress that the difference lies chiefly in the methods customarily employed by sociologists and social anthropologists, and not in theoretical differences between the two disciplines. The relevant distinction has been well stated by Paul[1], who notes that: "Sociology leans heavily on the use of questionnaires and interviews, most commonly single interviews of many

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persons. Anthropologists lean heavily on field notes, based on their own observations and, as a rule, on repeated and extensive interviews with fewer people . . . The primary job of an anthropologist is often not so much that of asking questions as finding out by a combination of ways what are the relevant questions to ask.

I do not intend to suggest that in the research work of the Ontario Foundation we either do, or feel we should, altogether neglect potential sources of data and avoid techniques commonly utilized by the sociologist. We are definitely sympathetic to the use of rigorous quantitative methods when the research question seems to require them. However, it seems to me that such methodology is only satisfactory when the area to be investigated is rather narrowly defined. Very often we do not know the relevant questions to ask, the answers to which might be sought through carefully controlled studies employing quantitative methods.

This is not equally true of all areas of social scientific interest in the alcohol field. For example, at the present stage of knowledge, sociological methods appear to be well adapted to studies of drinking behaviour in small groups, such as those now being conducted by the Finnish Foundation, and probably also to the investigation of attitudes, and of the effects of various forms of legal control.

On the other hand, there are many problem-areas, which currently seem of considerable importance, and about which extremely little dependable information is available. A few examples of these may serve to indicate more specifically the type of problem in which the Ontario Foundation is particularly interested, and which, as a first step towards solution, appears to require the more general exploratory approach of the social anthropologist.

Sex Differential

The first problem is that of a sex difference in the prevalence of alcoholism[3]. In all countries for which we have even the roughest measures there appears to be a difference in the prevalence of alcoholism as between males and females. This difference is usually quite marked, and always involves a higher frequency among males. For example, in Canada and the United States the ratio is about five male alcoholics to one female; in Switzerland the ratio is about 12 to one; and in some of the Scandinavian countries it may be 20 or more to one.

It seems hardly reasonable to postulate that women are somehow less subject than men to neurotic conflict, anxiety states, or other personality disturbances which might predispose to the

development of alcoholism — especially in view of the international variation in the ratio. Rather it is more likely that social and cultural factors are responsible.

A general explanation, frequently offered, is that the difference is due to what has been called the "double standard of morals", which means that there is greater social condemnation of certain behaviour—such as drunkenness or sexual promiscuity — when it occurs in women than of the same behaviour in men. Doubtless, such a differential attitude plays a part, but little can be done with the hypothesis in this form.

Jellinek Hypothesis

A somewhat better possibility, from the point of view of systematic research, derives from a recent theory of E. M. Jellinek[4] which may be called the "Vulnerability - Acceptance Hypothesis". This theory holds that in a country where the acceptance of drinking is very low — that is to say, where only a relatively small individual alcohol consumption and infrequent intoxication is tolerated — only highly vulnerable individuals will become alcoholics, for the most part.

In other words, the alcoholic population of such a country will tend to contain a relatively large percentage of psychotics and neurotics. Conversely, in a country where a relatively large daily consumption of alcohol is socially acceptable—for example, in France[5] —the percentage of psychotics and neurotics in the alcoholic population will be relatively small.

Moreover, since, in addition to other factors, an individual tends to be defined as alcoholic relatively later in his drinking career in a 'high acceptance' country, a relatively higher frequency of the organic diseases due to alcoholism (e.g. Laënnec's cirrhosis) may be expected than in the alcoholic population of a 'low acceptance' country.

It is clear that this theory has a number of weaknesses, and would have to be refined considerably to make it amenable to rigorous testing. For example, 'degree of acceptance' is difficult to measure, in practice, and the notion of 'vulnerability' is rather vague and difficult to define.

Useful Framework

On the other hand, it seems to provide a useful framework within which to begin an exploratory investigation of a problem such as that under consideration. Thus, if the difference in prevalence of alcoholism between males and females is at least in part due to a lower acceptance of drinking and intoxication in females, then a relatively higher frequency of the more serious personality disturbances might be expected

among female alcoholics. Likewise, a relatively lower prevalence of organic complications due to alcoholism, and manifestation of the so-called prodromal and addictive signs of alcoholic drinking at earlier ages might be expected.

Rough tests of the validity of these predictions could probably be made fairly readily employing clinical records, but, in any event, positive results would provide only rather tentative support for the theory. However, this and further exploratory work, involving, for example, extensive and relatively unstructured interviews with female alcoholic patients, might be expected to indicate some of the more significant variables, and to lead to the development of a more sharply defined hypothesis.

Rural-Urban Contrasts

A second problem of interest, which is similar in certain respects to that of the sex ratio in alcoholism is the problem of rural-urban differences in prevalence. It has often been pointed out, at least with respect to North American areas, that rates of alcoholism in cities are generally much higher than in small rural communities[6]. Again the possible role of a difference in the degree of acceptance of drinking comes to mind as a likely starting point. Some support for this possibility has already been obtained in an exploratory statistical investigation conducted in the Ontario Foundation[7]. In this study, the proportion of persons in each state of the United States voting against the repeal of Prohibition (1919—1933) was employed as a rough index of 'dry' sentiment. A highly significant negative correlation was found between this index and both degree of urbanism and estimated rate of alcoholism. In other words, the more rural the area, the higher the degree of dry sentiment and the lower the prevalance of alcoholism.

As a next step it might prove enlightening to compare two samples of alcoholics comprising in one case individuals of urban, and in the other, of rural background. Predictions similar to those made for males and females might be tested in this manner.

Alcohol and the Jews

A third problem which I would like to mention is that of alcohol and the Jews[8]. This problem is really a part of the much larger one of cultural differences in alcohol use and alcoholism[9].

The Jewish *alcoholic*[10] is perhaps of particular interest because of his rarity, and the consequent expectation that an understanding of the factors leading to the development of alcoholism in such an individual might throw considerable light on sociocul-

tural factors in the etiology of alcoholism in general.

The Jellinek "Vulnerability-Acceptance Hypothesis" may also have some utility in connection with this problem. Thus, the fact that drunkenness is evidently subject to very strong disapproval in Jewish groups[11] would suggest that only the most highly vulnerable, psychiatrically speaking, are likely to succumb, and that a long history of inveterate heavy drinking is likely to be rare and, accordingly also, the organic complications of alcoholism.

However, perhaps of greater interest is the likelihood of marked differences in the social history of Jewish alcoholics as compared with Jewish non-alcoholics—for example, as regards the frequency of intermarriage, extent of participation in various aspects of Jewish community life and the like. An exploratory study of this aspect of the problem was recently begun by members of the Ontario Foundation employing, as the principal source of data, a small number of Jewish patients who had appeared in the Foundation's clinic from time to time.

It is intended to treat these individuals as informants rather than as interview subjects in the usual sociological sense. In other words, each will probably be interviewed more than once; the problem will be put to them directly, and their co-operation in providing their own feelings and experiences will be sought. It is hoped in this way to obtain the information necessary to plan an adequately controlled and more carefully delimited investigation.

Skid Row

Let me now turn briefly to two problems of a rather different type, and ones which perhaps more obviously lend themselves to a traditional anthropological approach. The first of these is the problem of skid row. A great deal has been said about the so-called skid row areas of North American cities, particularly in propagandistic and condemnatory literature. But extremely little of scientific value has appeared.

Since the notion of skid row figures rather prominently in current conceptions of the drinking history of the alcoholic, objective first-hand studies of the nature and composition of what might be called 'skid row culture', would be of considerable interest. An essentially anthropological investigation is required[12] — possibly utilizing informants and especially direct, preferably participant, observation.

The Tavern

The final problem which I should like to draw to your attention concerns the role and functions of the tavern—that is to say, of public drinking places in general.

The tavern has been the object

of a good deal of discussion by various scholars concerned with the nature of its role in promoting drunkenness, alcoholism and other social problems. However, curiously enough, such students have usually been content to rely on logic and 'expect opinion' for data rather than to undertake direct empirical studies.

During the past few years a study of the social life and the drinking patterns associated with the tavern has been undertaken in Toronto at the instigation of the Ontario Foundation. Essentially the concepts and field techniques of the social anthropologist were employed. As a result of this work it is now possible to formulate a considerable number of relatively limited hypotheses which might be profitably tested by means of rigorous sociological methods. For example, a large number of variables which appear to influence individual drinking speeds and total consumption on any one occasion have been defined.

However, to establish with confidence the exact contribution of such factors requires the application of quantitative methods to the observation of drinking in a controlled situation, after the fashion of the small group research currently underway in the Finnish Foundation. Experimental studies alone are not sufficient because even if one knows the relevant questions to ask, there is always the unknown effect of an artificial situation. Accordingly, both approaches are necessary and might very productively work together in just such an area as this.

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Each issue contains pertinent, factual information selected primarily because of its interest to those who are called upon to deal with alcoholism professionally. Articles published do not necessarily represent the views of the Foundation.

If you would like to receive this publication regularly, or if you wish additional information about some aspect of alcoholism, you are invited to write to the Alcoholism Research Foundation, 9 Bedford Road, Toronto 5, Ontario (WA. 3-2474)

There are also branch offices at:
201 James St. South, Hamilton (JA. 7-4941)
481 Queens Ave., London (HU. 7-7434)
1206 Bank St., Ottawa (CE. 6-9717)

Edited by Vernon H. K. Lang

Circulation of this issue: 11,0

Vol. 6, No. 3
October, 1959

alcoholism

RESEARCH

TREATMENT

EDUCATION

Visiting Medical Director Reviews Treatment Of Alcoholism In Norway

*By Thorbjörn Kjölstad, M.D.**

NORWAY is a sparsely populated country. With her 3½ million inhabitants, there is just over one person per square kilometer. This population is not spread evenly over the country, but is clustered in a few larger towns and a great number of small villages and population centres around railroad stations. About 60% of the population, however, live within 200 kilometers of the capital, Oslo.

We estimate that there are some 40,000 alcoholics in Norway. This estimate is based on the Jellinek formula, and it corresponds quite well to the number of alcoholics who are reported to the authorities from one year to another. Between 60 and 70% of the alcoholics reported live in and around the capital, so that this area has undoubtedly more than its share of the alcoholic population. This is partly

**Dr. Kjolstad is Medical Director for the Treatment of Alcoholics in Norway. He recently spent a month in Toronto studying the treatment activities of The Alcoholism Research Foundation.*

due to the migration into Oslo of those who have already become alcoholics, but as in other countries we find more alcoholics in the industrial areas and towns than in the rural parts.

The treatment facilities are for the most part administered by the Ministry of Social Affairs. Those who come under the laws relating to "vagrancy, begging and alcohol abuse" are handled under the Ministry of Justice through the police and the courts; as it is, one can hardly say that these patients receive any treatment beyond a period of internment.

Under the Ministry of Social Affairs the work is divided between three authorities: the National Sobriety Board, the National Board of Education on Alcohol, and the Medical Director for the treatment of alcoholics.

Education

The National Board of Education on Alcohol takes a leading part in all propaganda and education on alcohol in schools and in the community in general. It arranges courses for school teachers and competitions for school children every year, and works in close co-operation with the local Sobriety Boards. The Board also edits a small journal on alcohol problems.

The National Sobriety Board coordinates the work of the local Sobriety Boards, and further gives information and instruction to these boards. Every year the National Board runs courses for the local boards, and has instructors who travel all over Norway.

Sobriety Boards

The local Sobriety Board is the kingpin in the treatment scheme. Every town and district has a Sobriety Board. The duties of such boards are to:

1) Work for sobriety generally in their district by giving advice to the local authorities about the sale and serving of alcohol in the district. They must make an annual report on their work and on conditions concerning alcohol consumption and alcoholism in the district.

2) Co-operate with the local schools with regard to alcohol education, and arrange essay competitions and in other ways stimulate the interest of the public in alcohol problems.

3) Take care of the alcoholics reported to the board and arrange treatment. The board has quite a lot of power in this respect and can intervene very actively when this is found necessary. The board is informed about an alcoholic by the family, by the doctor (with the patient's consent), by other official bodies, or by the patient himself. The board must examine the case thoroughly, and give advice and warning in the first place. If this is not

sufficient, the board tries to induce the patient to seek treatment, either ambulant at an outpatient clinic or from a private practitioner, or to accept admission to a clinic or rehabilitation centre. If the patient agrees, he signs a paper to that effect, and this, with further information from the board and from a doctor, is sent to the Medical Director.

If the patient does not agree to take treatment voluntarily, the board can decide that the patient shall go to a clinic or rehabilitation centre whether he (or she) wants to or not. On these occasions the board meets together with the local judge.

When the patient has signed the form, or the board has decided on coercion (less than 5% of the cases), the information goes to the Medical Director, who decides whether the patient shall be admitted to a rehabilitation centre, and allocates the patient to one of the different institutions.

Medical Director

At the moment there are 15 different institutions working directly under the Medical Director, with altogether about 800 beds. The institutions comprise clinics for short term treatment (up to 3 weeks), rehabilitation centres that can hold the patients up to a year, (average 5-6 months), and half-way houses that take the patients for up to 3 months. Three of the rehabilitation centres are run by the Government, the rest by private organizations, mostly with a religious background.

It is the Medical Director who decides on the duration of hospitalization, and on discharge the patient signs a form in which he promises to abstain from alcohol, and giving the Medical Director, in case the patient fails to fulfil the conditions, the right to bring him back to a rehabilitation centre within 2 years from the date of discharge.

Can Bring Patient Back

If the patient leaves a rehabilitation centre without formal discharge or leave, he can be brought back by the help of the police, whether the admission was originally voluntary or not. The Medical Director can also transfer the patient to any of the other institutions if this is found necessary.

The actual treatment in the rehabilitation centres is mostly psychotherapy, either individual or in groups. Drug treatment is little used, on the principle that it is no use exchanging alcohol for another drug, and the aim is to make the patient able to live without resorting to bottles or pill-boxes. The daily regime in the institutions is not strict, except concerning alcohol use.

Antabuse treatment is used only voluntarily, but the patient who

goes on leave must take antabuse beforehand.

Insurance

The stay at the centre is paid for by the Sick Insurance, which covers every Norwegian. If the patient was at work at the time he was referred to the centre, his family will have an allowance from the Sick Insurance as long as the patient is hospitalized. If the patient is not working at the time of referral, the local community, through the sobriety board, will maintain the family during the hospitalization. (This is not regarded as "poor relief," and the patient will not have to repay the community.)

The results of treatment are difficult to estimate, but roughly one third of the patients will keep dry for the future after discharge; one third will behave more socially; and the last third will fall back to their earlier pattern of life. Readmissions to rehabilitation centres are fairly common, but usually not more than twice.

The results will vary according to the work put into the aftercare, and we think the development of this part of the treatment is the most important task at the moment, together with better differentiation in the various institutions.

Probe Meaning of Memory Blackouts

SO FAR, no one has come up with a sure-fire way of predicting whether any one social drinker will or will not become an alcoholic. However, studies of thousands of alcoholic case histories have disclosed recognizable drinking patterns and experiences that are typical of various stages in the development of alcoholism.

Such early alcoholic experiences are warning signs which can be recognized by almost anyone who knows what they are—including even the alcoholic himself, although he may have difficulty in admitting them or accepting them for what they are.

Jellinek, in his "phases" concept of developing alcoholism,[1] divides the typical North American alcoholic's drinking history into four phases: pre-alcoholic, prodromal, crucial and chronic. Within these four, he identifies a total of 43 recognizable signs or symptoms.

In much of the Alcoholism Research Foundation's educational literature[2] these 43 symptoms have been condensed into "the 13 steps". For simplicity one can fur-

ther reduce these to five that are most easily recognized, namely:

1. Earliest memory blackout
2. Loss of Control
3. Solitary drinking
4. Acute hangovers and morning drinking
5. Benders

The earliest memory blackout does not always come before the other signs but it does occur early enough in enough cases to be worth special attention. Among alcoholic patients included in a study now being analysed at the Foundation, 84% had experienced one or more blackouts.[3] (the proportion of blackouts among non-alcoholics is not yet known.)

Stay Conscious In Blackout

The alcoholic blackout — also known as "pulling a blank"—is not to be confused with "passing out" meaning loss of consciousness; rather the blackout is an interval of amnesia which leaves a sobered-up drinker without recollection of what happened during some part of a drinking bout. Later, the alcoholic finds out (by waking up elsewhere and by hearsay) that he or she has definitely been active and conscious during the period of time that is missing from his memory.

Usually the gap in memory covers from one to several hours of the preceding evening. Isolated instances of people going to work for several days without remembering it are believed by some to represent a different process that may or may not be related to alcoholism.

Earlier studies[4] have led to a widespread belief that an alcoholic's first blackout usually occurs considerably before loss of control sets in. On the other hand a recent Ontario sample shows only 36.4% of patients reporting their first blackouts as occuring before first loss of control, 25.9% as occurring in the same year and 37.5% as occurring later than first loss of control.

Varies Between Countries

Looking at this subject from an international viewpoint, an expert committee meeting in 1954 under WHO auspices[5] observed that generally in the wine-growing countries blackouts were less common at early stages of alcoholism than in the English-speaking world and Scandinavia. However they observed amnesic episodes in wine-growing countries either among late-stage alcoholics or among those whose drinking was less spread out through the day than was customary in their country. In view of this, and of the fact that blackouts were most frequent in countries (a) with high distilled spirits consumption and (b) when drinking was normally concentrated at certain times of day, the W.H.O. expert committee suggested that quick changes in blood alcohol level might account for blackouts.

Human memories, like tape recordings, have to be first recorded and then, after an interval of storage, played back. Gaps in memory may occur when something has affected either the recording process or the tape in storage or the playback process.

Possible Causes

There have been cases of football players who, after suffering a concussion, have scored touchdowns against their own teams. Later, while under treatment for concussion, they did not remember anything about it. Such head-injury blackouts are believed to result from temporary physical impairment of the brain's ability to "record". Purely psychological causes,[6] such as what has been called "selective inattention" may also suspend the "recording" process.

Sometimes a blow on the head may cause loss of memory not only for the time of the blow but also for some time preceeding it. This lengthened gap seems more like accidental erasing of a recording tape during storage.

Finally, the trouble may lie in the "playback", as when the mind unconsciously refuses to recall memories that would, if brought to consciousness, create insufferable anxiety.[6] This last type of memory gap can often be filled in by a subject under hypnosis; while the type resulting from physical or other interruption of recording or storage cannot.[7]

Need More Research

There is need for more research on alcoholic blackouts, their relationship to the process of becoming an alcoholic and their timing in this process. Meanwhile they remain a dramatic symptom that is rather frequently associated with early and middle-stage alcoholism. Increased public awareness of the significance of blackouts should help social drinkers and those around them to distinguish more clearly between normal drinking patterns and incipient problem drinking.

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How Many Alcoholics? — Under Review

By John R. Seeley
Director of Research, Alcoholism Research Foundation

NOBODY has ever counted the exact number of alcoholics in any large area. Technical difficulties and very high costs prevent such a direct approach.

In spite of this, "estimates" have been made and published, [1] for many parts of the world: countries, states, provinces, and sometimes even cities. These estimates all rest on a formula devised about 1940 by Dr. E. M. Jellinek, a formula which infers the probable number of alcoholics from the number of deaths from liver cirrhosis. [2] [3] This is possible becaue some alcoholism leads to liver cirrhosis (although, of course, not all liver cirrhosis is due to alcoholism). What Dr. Jellinek wanted was a rough estimate of the numbers of people in the population at large whose condition was similar to that of people being observed in alcoholism clinics.

Re-examine Formula

This formula well served Dr. Jellinek's original purpose which was to draw attention to alcoholism as an important public health problem. Partly because of his estimates, the condition began to receive some of the attention it deserved. As it received such attention, and particularly as researchers needed rather exact figures to work with, this method of estimating came under critical review in many places, but particularly in the Alcoholism Research Foundation of Ontario.

Seek Improved Method

Engaged in this extensive re-examination of the Jellinek Formula have been the Foundation's Director of Research, the Assistant Research Director, Robert E. Popham, and Dr. E. M. Jellinek himself, who has been associated with the Toronto group since 1958. The June 1959 issue of Yale University's Quarterly Journal of Studies on Alcohol contains no less than three articles on the subject: one by Jellinek [4], one by Brenner [5] (of the U.S. Public Health Service), and one by Seeley [6]. All three want to improve the present way of estimating or find a new way.

The recent annual meeting of the North American Association of Alcoholism Programs at Cape Cod, Mass., took note of these analyses and their implications and agreed with the three authors that the search for a new basis of estimating rates should be pursued with diligence. One idea put forward at the

meeting concerns the possibility of correlating alcoholism with some measurable condition other than deaths from cirrhosis of the liver Any new method would of course need corroboration by a series of carefully designed and executed field surveys (similar, perhaps, to the one conducted by the Alcoholism Research Foundation in [7] "X" County of Ontario in 1951).

May Underestimate

Until we have these new estimates, the opinion of authorities in the field is that we may look on the old ones as, probably, underestimating rather than overestimating the prevalence. If the formula now in use is applied with proper care to fairly large populations, the result is almost certainly smaller than the actual number of alcoholics at large in the population. So we are not likely to be overestimating the problem. All we can say, with reasonable safety, to the citizens of a given province or other unit is "You have *at least* this many alcoholics." We cannot safely infer from present estimates that any area has a higher or lower rate of alcoholism than any other.

Latest Rates

With all these qualifications noted, the Foundation would now say (still necessarily based on the Jellinek formula) that there are in Canada *at least* 2,010 alcoholics per 100,000 adults (20 years and older) or, at least 199,000 alcoholics altogether. In Ontario, it would say there are at least 2,200 alcoholics per 100,000 adults (20 years and older,) and the total number of alcoholics in the province is at least 78,000. These latest estimates are for the year 1957, the last year for which necessary death statistics are available.

The Foundation is no longer willing to make comparisons between provinces or countries, or even from one year to another for the same area, because the extent of underestimation in Jellinek Formula estimates may very well vary quite considerably from place to place and from time to time.

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A.R.F. ACTIVITY NEWS

OCTOBER 1959

Continue Courses for Professions

Physicians. A 1½-day seminar course for physicians, especially those in general practice, is being held at the Alcoholism Research Foundation's Toronto Clinic, Friday and Saturday, Nov. 13-14, 1959. This is under the joint auspices of the Foundation and of the College of General Practice of Canada. Attendance at this course, which will be limited to 25, qualifies members of the College of General Practice for formal study credits.

Clergymen. The Foundation's fourth annual clergy workshop, arranged in co-operation with the Christian Social Council of Canada, takes place this fall, with participating clergymen meeting at the Foundation's Toronto headquarters for six successive half-day sessions on Tuesdays during October and November.

Teachers. The Hamilton Board of Education is sponsoring in co-operation with the Foundation a one-day seminar on alcohol education for selected high school teachers, November 23.

Frontier College. Training courses, held in the spring and fall of this year by Frontier College for its instructors who work and teach in frontier industries, have each included a half-morning session led by a representative of the Alcoholism Research Foundation.

Recent Scientific Articles by A.R.F. Staff

Alcohol, Alcoholism and Introversion-Extraversion, by Muriel Vogel, A.R.F. Senior Research Assistant (Canadian Journal of Psychology, June 1959). Reviews Eysenck's personality theory of introversion-extraversion and suggests ways in which it could relate to selection of treatment methods and to histories of alcoholics.

Critique of the Manson Evaluation Test, by R. J. Gibbins, R. Smart and J. R. Seeley (Quarterly Journal of Studies on Alcohol, June, 1959).

Estimating the Prevalence of Alcoholism, a series of three separate articles (Quarterly Journal of Studies on Alcohol, June 1959). Discussion by B. Brenner of U.S. Public Health Service, and (separately) by John R. Seeley and E. M. Jellinek of the Alcoholism Research Foundation on need for revision of widely used Jellinek Alcoholism Estimation Formula or development of some new estimating methods. (see also article on page 5 of this issue of Alcoholism—Research, Treatment, Education.)

Note on Alcoholics and Drunk Driving, by W. S. Schmidt and R. G. Smart(Criminal Law Quarterly, Feb., 1959) Studies possibility that many drunk drivers may be alcoholics and therefore needing treatment rather than conventional safety education or law enforcement.

Social and Cultural Aspects of Alcoholism, by R. E. Popham (Canadian Psychiatric Association Journal, October, 1959). Discusses role of attitudes toward beverage use in relation to prevalence of alcoholism, with reference to rural-urban, sex and ethnic differences.

The W.H.O. Definition of Alcoholism, by John R. Seeley, Research Director, A.R.F., (Quarterly Journal of Studies on Alcohol, June, 1959). A critique of the adequacy of this well-known definition of alcoholism.

The Withdrawal Syndrome in Alcoholism, by E. M. Jellinek (Canadian Medical Association Journal, Oct. 1, 1959) discusses current knowledge about withdrawal symptoms and concludes that psychological factors alone are insufficient explanation: physiological factors must be present as well.

Announce New Appointments

Dr. C. L. Bates, a past president of the Hamilton Academy of Medicine has been appointed Chairman of the Medical Advisory Board of the Hamilton Branch of the Foundation.

Alan M. Marcus, M.A. (Social Psychology) has been appointed to the new position of staff assistant—evaluation, on the head office staff of the Foundation's Education Department.

Kenneth M. Green has been appointed social worker at the Foundation's London Branch.

Miss M. Irene Allen and **Miss Kathrine B. Dicks** have been appointed social workers on the staff of the Foundation's Toronto Clinic.

H. David Archibald, executive director of the Foundation, has been elected a Director and Associate Editor of the Quarterly Journal of Studies on Alcohol, published at Yale University.

White Cross Volunteers Help Clinic

There are now seven active White Cross Volunteers, three men and four women, assisting the recreational activities for patients at the Toronto inpatient clinic of the Alcoholism Research Foundation. The program is planned to cover, eventually, every night in the week. So far, there are no volunteers for Friday, Saturday or Sunday activities, and more help could be used on other evenings as well. Potential vounteers are invited to discuss the program with Mr. Wm. Miller, the clinic group social worker.

Send 10 to Yale Summer Course

The Ontario Alcoholism Research Foundation sent 10 representatives of various professional fields to the 1959 Summer School of Alcohol Studies at Yale University. Included were: two probation officers from Hamilton, Miss Joan Frith and Mr. John K. Mildon; the Ontario Hospital (Hamilton) group work supervisor, Mr. Allen C. Cutcher; a training division chief from the Dept. of Defence Production, Ottawa, Mr. Robert Dennison; Miss Agnes Clinton, a public health nurse from East York; Miss Hazel Ward, a McMaster University instructor in nursing; Sidney Katz, Associate Editor of MacLean's Magazine; and three Foundation staff members: Mrs. Betty J. Constable, Librarian; Miss Betty J. Kinch, R.N.; and Mr. Kenneth M. Green, social worker of the London Branch.

Chicago Survey — A New Perspective On Real Complexity Of Skid Row

THE words "Skid Road" or "Skid Row" bring to most people who have heard of them a mental image of numerous rather down-and-out alcoholics living in a dilapidated section of town.

The experience of Alcoholics Anonymous and of modern alcoholism treatment clinics has shown pretty clearly that skid-row alcoholics are not necessarily typical alcoholics, nor are most alcoholics on skid row. Nevertheless, skid row continues to be a rather conspicuous social problem. Efforts to "shrink skid row" by penalties, preaching or psychiatry have certainly rehabilitated some people, but their impact on the total size of the skid row problem has not been at all spectacular.

Dramatic documentary journalism has vividly portrayed this stubborn problem as the hard core or arch-type of some larger problem. Depending on the predilections of the observer, the larger problem that skid row typified has been variously viewed as drink, housing, unemployment, law enforcement, inflation, lack of religion and so forth.

Perhaps the skid row problem is no single one of these, but is instead a sort of catch basin into which certain products of all these problems seem to flow. Sociologists describe skid row as a "deviant subculture." The police, the courts and the alcoholism clinics study the "c h r o n i c drunkenness offender." City planners are concerned with rehabilitating a geographical area.

Study Homeless Man

Recently, an intensive survey of Chicago's skid row areas has been sponsored by the U.S. Federal Housing Authority and the Wieboldt Foundation and carried out by the National Opinion Research Center. The preliminary report on this study of "The Homeless Man on Skid Row" indicates (among many other things) that:—

1. Probably less than one-third of the homeless men on skid row are alcoholics;

2. The remainder, a majority, are homeless men who live in skid row areas because they cannot afford to live in better surrounding;

3. The amount and type of gainful employment among skid row residents is a function of many influences among which drinking habits are only one;

4. "Any conception of skid row as a tightly-knit, well-integrated and organized community, where most of the residents interact freely and have a common culture and tradition, is a complete myth."

The Chicago Survey bases its conclusions mainly on study of interviews with 614 men from certain selected parts of Chicago. Regarding drinking practices, the authors of the study have classified their skid row population as follows:

Drinking Classification*	Percentage of men in the sample	Number of homeless men on Skid Row
Total	100.00	11,926
Teetotalers	14.8	1,765
Light drinkers	28.4	3,375
Moderate drinkers	24.4	2,910
Heavy drinkers	19.8	2,373
Alcoholic derelicts	12.6	1,503

In summarizing the mass of socio-economic data about skid row residents, as presented in the problem drinking section of the preliminary report, the authors build up a composite picture of two basic groups to be found among these men. Here is what they say:

"Group A—Homeless men who live on Skid Row because they are poor

"These men have accumulated from the most poverty-stricken segments of Chicago and the nation. Many of them are old men who live on very small pensions (Social Security, military pensions, or public welfare). Others are the least educated, most unskilled, and least employable men in the labor force and hence the ones who have "lost out" in the competition for better jobs. Many are immigrants from Europe who "failed to make good" and who have reconciled themselves to living on Skid Row. Here also are the non-alcoholic Negro from the South who has been unable to find work, and the widowed old man who has no relatives with whom he can live and who is no longer able to work. Here are the men who have steady employment, but at jobs that pay substandard wages. The migrant worker who has come to the city to find work, who has exhausted his funds and is taking spot jobs or just any job to get along, is also in this group.

See list of criteria in note on page 18

"These men who control their drinking are not necessarily "lost souls" in the sense used by the mission preacher whose sermons about repentance they endure in order to eat, but tend to be "lost souls" economically, in the sense that at the present time they can only look forward to a life of economic hardship. They are the men hardest hit by inflation, the losers in the competition for steady jobs, and those who got consolation prizes when the steady jobs were handed out.

"Group B—Homeless men on Skid Row who are alcoholic derelicts or heavy drinkers.

"These are young or middle-age men who are irregularly employed, either as spot job workers, as railroad maintenance men who draw "rocking chair" or other unemployment compensation, or those who just beg other homeless men for drinks and live off the missions. A small percentage qualify for public assistance, but use as much of their living allowance for drinking as they can manage to convert.

"They tend to be native born Americans whose parents were native born — and a disproportionately high percentage of them are of Irish ancestry and come either from the Southern U.S. or from a metropolitan area. A large percentage are in good physical health, except for the more or less temporary condition induced by their excessive drinking, and could be physically rehabilitated to be either only slightly handicapped or not handicapped at all. But they would still be left with their drinking problem unresolved."

In commenting on the light and moderate drinkers in Group A, the authors suggest that many of these may later become heavy drinkers.

Gainful Employment

About 40% of those interviewed had worked at some job during the week preceding the day they were interviewed, while 60% had not. Of those who had not been working about 46% blamed this fact on age, disability or temporary illness. Another 40% were involuntarily unemployed, this being partly accounted for by the fact that the interviews were conducted mainly in January and February of 1957. A further 15% were classified as "did not care to work"; 4% admitted to being "on a spree", while the remainder gave various other reasons.

Neither the teetotalers nor the light drinkers were most often recently employed; instead, the mod-

Two Good Discussion Films For Adults

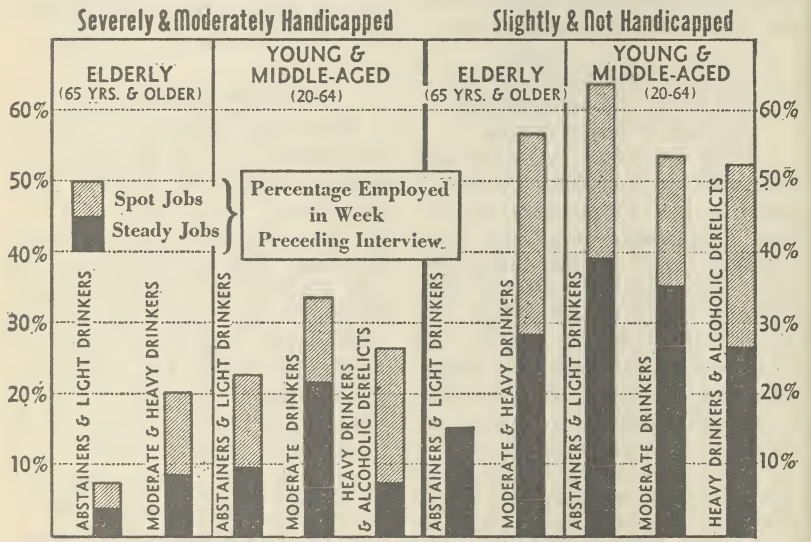
Profile of a Problem Drinker	29 min. b & w
How Long the Night	30 min. b & w.

In Ontario, prints of these may be borrowed free from Education Dept. Alcoholism Research Foundation, 9 Bedford Rd., Toronto 5, WA. 3-2474.

erate drinkers had the highest percentage of men working. When the authors turned to study the relationship of drinking patterns to other factors that might affect employability they developed a drinking-disability-age classification which gave a clearer picture. A portion of the resulting data is illustrated in the chart below.

PERCENTAGE OF CHICAGO SKID ROW RESIDENTS EMPLOYED DURING WEEK PRECEDING INTERVIEW

(By Drinking — Disability — Age Classification)
Winter 1957



It should also be noted that of all the younger and middle-aged men on skid row (including those unemployed at the time of the survey) 82% had worked at some job sometime during the year preceding the interview regardless of how they were classified as to drinking. Even among the alcoholic derelicts, 88% had worked at some time during the preceding year.

For most of the men living on skid row, work opportunities are concentrated in the lowest paying most irregular and most disagreeable tasks. Their major sources of employment are: restaurants, large department stores, factories, ware-

houses, railroad (track maintenance men), trucking firms and freight handlers, advertising firms (bill peddlers), garage and filling stations (car washers), skid row hotels, (janitors and porters), bowling alleys (pin setters), hospitals (kitchen and clean up help), religious organizations.

Physical Conditions

Five separate areas studied in Chicago were selected to meet the following criteria; (a) areas in which the rent was less than $2.00 per night or $12.00 per week, (b) where men comprised more than three-quarters of the residents, and (c) areas which had such general skid row characteristics as: employment offices for unskilled labour, many taverns, barber colleges, cheap clothing stores, missions and second-hand stores.

About two-thirds of the men in the sample were living in cubicle hotels. Generally speaking these are dormitory type accommodations in which each resident rents a bed contained in a space roughly five feet by seven feet, separated from its neighbours by thin partitions which do not always reach either to the ceiling or the floor.) Another 14% were living in hotels with rooms, 6.8% in rooming houses, 8.2% in missions and the remainder in hospital, in jail, or sleeping out.

A Street Divided

One of the five areas considered to be skid row areas contained, relatively and numerically, more alcoholics than any other. However, it seems clear that no matter how narrow one's geographical definition of Skid Row, no single area would have anything like a complete alcoholic population.

In their chapter on What Homeless Men Think of Living on Skid Row, the authors point out from tabulation of the men's opinions that Skid Row is a street divided over the issue of heavy drinking. The two-thirds whom they classify as non-drinkers, light drinkers or moderate drinkers dislike living among the one-third who are heavy drinkers or periodic drinkers. Paradoxically this dislike is often expressed by the heavy drinkers themselves during sober periods.

While the survey sought opinions on, for example, housing conditions, the answers in this section stressed dislike of social situations and of people far more often than dislike of particular places of abode. From this evidence the authors concluded that it would be a mistake to regard Skid Row as a community where most residents interact freely and have a common culture and tradition. Instead, Skid Row seems to be composed largely of discontented individuals who live in semi-isolation and who have few if any close friends.

There is of course a minority who do have many friends on Skid Row and who appear to like living

(Continued on page 19)

HOW DRINKING PRACTICES WERE CLASSIFIED IN CHICAGO SKID ROW SURVEY

Teetotaler—a person who said he never drinks and for whom there was no evidence to controvert his claim, including the observations of the interviewer.

Light drinker—a person who says he is a light drinker and who spends less than 15 percent of his income on drinking, and who drank less than 3 pints of whisky (or equivalent) during the week preceding the interview. Also included are persons who said they were moderate drinkers, but who drank less than 2 pints during the preceding week and spend not more than 10 percent of their income on drinking.

Moderate drinker—a person who says he is a moderate drinker and who spends between 15 and 35 percent of his income on drinking and who drank not more than 5 pints of whisky (or equivalent) during the week preceding the interview. Also included are men who called themselves "light drinkers" but who spend 20 to 40 percent of their income on drinking, men who call themselves "heavy drinkers" but who spend less than 20 percent of their income on drinking and drank less than 5 pints in the preceding week, or periodic drinkers whose spells of drinking are spaced 3 or more months apart and who spent less than 35 percent on drinks.

Heavy drinker—a person who says he is a heavy drinker and spends 25 percent or more of his income on drinking or who drank 6 or more pints of whisky (or equivalent) during the week preceding the interview, or who says he is "light" or "moderate" drinker but spends 40 percent of his income on drinking and drank more than 5 pints of whisky (or equivalent) in the week preceding the interview.

Alcoholic derelict—a long-time drinker who has sacrificed almost everything for drinking. These men qualified as heavy drinkers and in addition (1) have been arrested at least 10 times for drunkenness (one of which times was in the last six months), (2) have one of the following: (a) a health condition attributable to prolonged drinking, (b) had D.T.'s one or more times, (c) spend 65 percent or more of their income on drinking, (d) have been in hospital one or more times as a result of drunkenness. If there was no record of jail or arrests, a heavy drinker was classified as an alcoholic derelict if he had 2 or more of the conditions listed above that did not refer to the same episode of drunkenness.

NOTE: *The accompanying article about the Chicago skid row survey interprets "alcoholic" as being roughly equivalent to the last two of the above categories. While this is not diagnostically accurate, it is perhaps as refined a classification as is possible with the survey methods being used.*—ED.

there. Further study is being devoted to this group.

Other Skid Rows

As part of the overall Chicago study, letters were sent to responsible officials in all American cities of 50,000 people or more, requesting information about areas which were considered to be skid rows. At least 50 skid rows were described in the replies received and, from studies of census data on census tracts containing 45 of these skid row areas, it was estimated that they contained about 100,000 homeless men altogether.

The concentration of men in skid row areas seemed to be greater at major port cities, major railroad centers and manufacturing or mining towns that require a large supply of manual labour as well as in regions where migratory labourers are needed to harvest crops.

Certainly, we in Canada have cities that fit these categories and do, as one would expect, have sizeable skid rows of their own. Each Canadian skid row would be much smaller than Chicago's skid row areas as a group, but possibly not much smaller than any one of the five sub-areas that were involved.

A more detailed study of the Chicago findings would be of value to any Canadian organization or municipality contemplating action to deal with its skid row problem, whether the concern was with alcoholism alone or with the larger complex of influences which seems to be at work in either the social or geographical area that becomes known as skid row.

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Some 16mm. Films For Teaching About Alcohol

TO YOUR HEALTH — 10 Minutes, Colour Animation

A World Health Organization Film

Technical Advisor: Dr. E. M. Jellinek

Comprehensive, tightly packed presentation of practically all aspects of both normal and problem uses of beverage alcohol. Portrays a variety of typical extreme attitudes toward alcohol, then some typical social uses generally accepted in certain cultures. Contrasts these with abnormal and alcoholic uses. Graphically describes functioning of alcohol in body. Typical sequence of behaviours by an alcoholic is followed by short outline of modern treatment for alcoholism which can release alcoholic from compulsion to drink.

Suitable for all ages and interests, although concentration of so much material in short time makes it advisable for most audiences either to see it twice (before and after discussion) or only after introductory discussion.

WHAT ABOUT ALCOHOLISM — 10 Minutes, Black and White

A Raymond McCarthy Film

(Young America Films—Now part of McGraw-Hill Text-Film Dept.) Showing high school students who decide to investigate alcoholism in their community. They get information from a judge, from an industrial employment manager, and from parents with various views. Resulting information and opinions are then discussed in classroom. Those in film do not reach unanimous conclusions, leaving subject open for audience to carry on discussion afterward. Primarily a discussion-starter film for high school students, although parent-groups could also make use of it.

WHAT ABOUT DRINKING — 10 Minutes, Black and White

A Raymond McCarthy Film

(Young America Films—Now part of McGraw-Hill Text-Film Dept.) Presents discussion by teen-agers in party setting without adults, in which young people themselves bring out various views on drinking. Views of parent, clergyman and doctor are also brought in through periodic shifts away from all-teen-age party setting. None of opinions expressed are labelled right or wrong, leaving subject open for audience discussion afterward. Another discussion-starter film for students and possibly parents.

For loan of prints contact Education Department
Alcoholism Research Foundation, 9 Bedford Road, Toronto 5.

Vol. 7, No. 1 Spring, 1960

alcoholism

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ANNUAL REPORT ISSUE

This periodical is published four times a year in the interests of a deeper understanding of the widespread disorder alcoholism.

Each issue contains pertinent, factual information selected primarily because of its interest to those who are called upon to deal with alcoholism professionally. Articles published do not necessarily represent the views of the Foundation.

If you would like to receive this publication regularly, or if you wish additional information about some aspect of alcoholism, you are invited to write to the Alcoholism Research Foundation, Education Department, 17 Prince Arthur Ave., Toronto 5, Ontario (WA. 5-8951)

There are also branch offices at:
201 James St. South, Hamilton (JA. 7-1941)
481 Queens Ave., London (HU. 7-7434)
1206 Bank St., Ottawa (CE. 6-9717)

Edited by Vernon H. K. Lang *Circulation of this issue: 13,000*

Vol. 7, No. 1
April, 1960

alcoholism

RESEARCH

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This Issue—A Digest of Annual Report

This issue of ALCOHOLISM is devoted entirely to information contained in the newly published ninth annual report of the Alcoholism Research Foundation.

While the complete 96-page report is available to those who request it, most of the highlights are included here, either as summaries or extracts.

It is hoped that in this way the thinking that goes into the Foundation's annual report will come to the attention of a broader audience than would normally be able to go through the report itself in full.

ALCOHOLISM RESEARCH FOUNDATION

TERMS OF REFERENCE

In the past few annual reports an outline of the sphere of authority of the Foundation was presented. For the benefit of those who are not familiar with the work of the Foundation, sections 2, 7 and 7A of the legislation defining our terms of reference are quoted:

"2. There shall be a body corporate to be known as the Alcoholism Research Foundation composed of not less than seven and not more than ten members appointed by the Lieutenant-Governor in Council."

"7. The objects of the Foundation shall be and it shall have power,

(a) to conduct and promote a programme of research in alcoholism; and

(b) to conduct, direct and promote programmes for,

(i) the treatment of alcoholics

(ii) the rehabilitation of olcoholics,

(iii) experimentation in methods of treating and rehabilitating alcoholics, and

(iv) dissemination of information respecting the recognition, prevention and treatment alcoholism."

"7a. (1) For the furtherance of its objects, the Foundamay,

(a) establish, conduct, manage and operate hospitals, clinics, and centres for the observation and treatment of and for consultation with alcoholics; and

(b) enter into agreements,

(i) with hospitals and other institutions for the accommodation, care and treatment of alcoholics,

(ii) with universities, hospitals and other institutions for the experimentation in methods of treatment of alcoholics.

(2) The Foundation may make grants to the institutions referred to in clause b of subsection 1 for purpose of carrying out such care, treatment and experimentation."

Chairman Reviews Past Growth of Alcoholism Research Foundation *

Ontario was the first province in Canada to establish an official organization, the Alcoholism Research Foundation, for the express purpose of finding out how best to deal with the problem of alcoholism. Since 1950 the Foundation has:

* Carried out or sponsored some 100 separate research projects in scientific fields related to alcoholism;

* Established and operated in separate Ontario cities four small pilot clinics for the treatment of alcoholism; which clinics, while intended primarily for research, have to date treated more than 7,000 individuals out of the estimated 80,000 alcoholics in Ontario;

* Systematically passed on its growing knowledge about alcoholism to professionals in medicine, nursing, social work, religious counselling and other fields where potential help for the alcoholic in the community can be found;

* Established itself, provincially, nationally and internationally, as an impartial and helpful source of information on alcoholism and alcohol problems generally; thereby bringing, through various means of publicity and education, greater understanding of these problems to substantial numbers of citizens.

These activities were begun on a small scale. Gradually, as interest was developed in alcoholism and in the Foundation, highly competent scientists have come into the field

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* Chairman of the Alcoholism Research Foundation is Mr. I. P. McNabb. This article is condensed from his introduction to the Foundation's Ninth Annual Report.

and the organization has grown in size, accomplishments and reputation.

Three branches with out-patient clinics have been established, in London, Ottawa, and Hamilton; while at our Toronto headquarters, in-patient and out-patient facilities plus research and education departments, have spread out into four buildings. A new building is now being planned to re-unite the Toronto units.

A new drug Temposil (citrated calcium carbimide) has resulted from one type of research sponsored by the Foundation. In various ways much of the knowledge of treatment we have accumulated is being passed on to physicians, to other professionals and to the public.

The broad nature of our research program has attracted international recognition. As a result, members of our staff are serving on several international scientific and professional bodies, some of which are receiving heavy financial support from the United States Department of Public Health.

Executive Director Looks Forward At Possible Future Developments *

The year 1959 has been in many respects a turning point in the history of the Alcoholism Research Foundation and indeed in the entire field of specialized endeavour in relation to alcoholism.

* Within our Ontario organization we are on the threshold of a rapid expansion of our own facilities for research, treatment and education at Toronto.

* Within Ontario but outside of the Foundation itself there has been a marked increase in interest in special aspects of the alcoholism problem, such as drinking drivers and chronic drunkenness offenders.

* Within Canada but outside of Ontario, two provinces, Quebec and Nova Scotia, have been added to the four others (the western provinces) which had already followed Ontario's lead in establishing specialized units to deal with the alcoholism problem.

* Within North America but partly outside Canada, increasingly active leadership has been extended by our own organization and others through the North American Association of Alcoholism Programs. This has attracted the interest of the United States Department of Public Health, which, as a result, is now providing substantial grants to NAAAP with which it is organizing a new Co-operative Commission for the Study of Alcoholism.

Within Ontario

Since the Ontario Foundation's present Toronto clinics and headquarters lie across the route of Toronto's new east-west

* Executive Director of the Alcoholism Research Foundation is Mr. H. David Archibald, M.S.W. This article and the next four articles are condensed from his annual review of operations contained in the Foundation's Ninth Annual Report.

subway, a temporary move is under way to be followed by construction of a new building to re-unite all departments in one efficient unit.

The laboratories and clinical facilities now being planned will expedite and broaden the range of our study of alcoholism and related problems.

For example, our research department will be able to have its own laboratories; our treatment department will have its first facilities in which to study treatment of acute intoxication; our education department, in co-operation with the others, will have the kind of space it needs to step up aspects of its work dealing with groups of professional people.

Such improved conditions should result in greatly accelerated advances in our knowledge of alcoholism, of the most effective treatment and control techniques, and of effective translation of this information into action throughout Ontario.

The location of our new headquarters, close to the heart of the University of Toronto and accessible to three major teaching hospitals, will provide new opportunities, both for research and for the training of the several professions which can contribute to the treatment of alcoholism.

Related Problems

Apart from our central concern about alcoholism as a specific illness, there are several related problems, an understanding of which is essential for fuller understanding of alcoholism itself. The coming expansion will provide for needed attention to such matters as addiction to other substances than alcohol, public drunkenness, alcohol and driving, alcohol and tuberculosis, and many others.

In regard to public drunkenness the Government has asked the Foundation to plan the establishment of two special receiving centers in which a representative sample of cases from the courts may be examined.

Branches

For varying lengths of time the Foundation has maintained branches in certain other communities in Ontario outside of Toronto. These have been basically centres for out-patient treatment and for community education work.

From the beginning it has been expected that the approach taken in each branch would vary according to local circumstances and the interests of those in charge. This has taken place and the result has been several different sets of experiences that are of considerable value to the Foundation as a whole.

Main Contribution to Treatment

The Foundation has always felt that, as a research institution, it could make its greatest contribution, not by becoming involved in the provision of institutional treatment on a mass scale, but by discovering the best methods and communicating them to others.

Much of the needed treatment effort can be provided, not by new institutions but by existing professional resources — physicians, clergy, social workers, etc. — in private practice and in existing community institutions. This likelihood has led the Foundation to seek every opportunity to have professionals spend some time within our organization, both during their initial professional training and later on a refresher basis. As a result there are signs that a more positive approach to alcoholism is now being taken in the many institutions and agencies and also in private general practice.

However, despite all the scattered work that can be done by the individual professional with knowledge in this field, there still remains a need for a greater number of specialized alcoholism treatment centres than exist at present. When the time comes to establish a chain of such organizations, the Foundation will be ready and willing to play a leading part in the planning, staffing and training that will be involved, but probably not in the continuing administration of such facilities.

Preventive Education Opportunity

The earliest signs of impending alcoholism need to be more widely known. If everyone were able to recognize them, it would be a tremendous step forward toward preventing alcoholism or arresting its development early.

However matters related to the drinking of alcoholic beverages are often so contentious that special care has to be exercised in dealing with them. Here more than in other fields, the selection of factual content, methods of presentation, and media are critical. Sources of data must be above suspicion; and the feelings and prejudices of different parts of the population must always be kept in mind.

Our education department has tested its ideas and methods sufficiently to warrant bringing forward a plan for a greatly expanded province-wide education program. Further, in October 1959 the department added to its staff a social psychologist whose special field of study is mass communications; and the large-scale education program can therefore have built into it from the start the principle of continual assessment and the potential for re-focusing and improvement as it proceeds.

Research Knows No Boundaries

In scientific research, more perhaps than in many other fields, "no man is an island". No research institution can hope to make progress for long in isolation from continuing contact and co-operative endeavour with others working in their own and related fields in other institutions and communities.

The developments now taking place in Canada and the United States, both in knowledge about alcoholism and in organization to deal with it, are of vital importance to the continuing refinement of our knowledge and methods. The Ontario Foundation takes considerable pride in the fact that members of its staff have played a large part in the process of injecting new thinking and leadership into the endeavours of others throughout the world.

Review How Many Are Alcoholics,[1] Who They Are and Related Problems

Perhaps the most far-reaching project of the Foundation's research department during 1959 has been its contribution toward critical examination of methods presently used to estimate the number of alcoholics in any given area at a particular time. Up to now such estimates all rest on a formula devised about 1940 by Dr. E. M. Jellinek, a formula which infers the probable number of alcoholics from the number of deaths from liver cirrhosis.

While such estimates may have been accurate for the early years they cover, our recent studies have shown that the methods we have for estimating today's alcoholic population can no longer be viewed as accurate. The opinion of several authorities in the field is that existing methods probably underestimate rather than overestimate the total of alcoholism.

At Least 80,000 in Ontario

The search for better ways of estimating is being given high priority. Meanwhile, based on present methods, all we can say is that there are in Canada at least 200,000 alcoholics of whom at least 80,000 are in Ontario.[2]

These figures simply tell us roughly how many people there are whose condition is like that of people who turn up in clinics for the treatment of alcoholism. They include both those who have been successfully treated and the much larger number who have either failed to accept treatment or have never sought appropriate help at all.

There are many varieties among such people: a fully descriptive definition of who is included would take many

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[1]See footnote on page 5

[2]These figures are based on Jellinek formula calculations applied to the cirrhosis death rates (1957), with the resulting alcoholism estimates rounded to the nearest 10,000. The extent of underestimation in Jellinek Formula estimates may very well vary quite considerably from place to place and from time to time; consequently we are no longer publishing comparative estimates for different places and different years.

pages. For a fairly concise definition, one may quote the World Health Organization, which describes alcoholics as:

> *". . . those excessive drinkers whose dependence upon alcohol has attained such a degree that it shows a noticeable mental disturbance or an interference with their bodily or mental health, their inter-personal relations and their smooth economic functioning. . . ."*

The key word in the W.H.O. definition is "dependence". This roughly distinguishes alcoholics from others who have (or create) problems by their drinking, without being similarly dependent. For example, until recently, persons appearing in court on charges of public drunkenness or impaired driving were looked on (by those familiar with alcoholics) as quite a different problem from the alcoholics.

Offender Groups

On the other hand, the numbers of such people appearing in court on such offences (more than 20,000 publicly drunk and about 8,000 on impaired or drunken driving charges in Ontario each year) are so large, and the amount of repetition is so great, that the public and the authorities dealing with the offenders may well feel that the repeaters at least are alcoholics.

The important thing is to find out more about these people. Only by special research in this field can we determine how many of them actually are alcoholics (for whom modern treatment is indicated) and how many need some other form of penal, educational or rehabilitative measures.

Discuss Proposals For Laws To Direct Some Into Treatment*

One type of case in which some legal intervention may be required is the defiant or incorrigible alcoholic who is completely resistant to any suggestion that he undertake treatment. When such a person constitutes a periodic danger to those around him, some means is needed to remove him to a place where he might at least be exposed for a reasonable length of time to some effort to help him recover from his illness.

The Medico-Legal Society of Toronto has proposed a new Habitué Act (to replace certain parts of the present Mental Hospitals Act) which could deal with more such cases than are handled under existing legislation.

The proposed legislation deserves careful consideration, partly because it raises important questions about civil liberties, and partly because if passed it would be meaningless unless additional treatment facilities were provided to cope with the flow of patients which might result.

Even the possibility of easier commitment than under present laws might tend to indirectly encourage a big increase in the pressure for admission to voluntary treatment facilities. On the other hand, the introduction of any new and fair provision that might increase the number of committals for treatment should not on that account be delayed beyond the time necessary to establish enough treatment facilities, starting now.

Two-fold Role of Legal Action

Treatment must ultimately be accepted by the patient himself and this means that enforced commitment may not necessarily result in as high a rate of success as with purely voluntary patients. The role of legal action, if it has any, should be two-fold: to protect others who are being harmed by an alcoholic (whether because of his alcoholism or not), and to at least expose the patient for a reasonable time to some treatment, with the likelihood that given enough exposure he may ultimately accept it.

* See footnote on page 5

Suggest Research Has Implications For Traffic Safety Administration*

Taking the driving field, recent statistical studies among the Foundation's patients have shown that about one-quarter of all drivers convicted of impaired or drunken driving would be expected to be alcoholics. This information, together with other research, suggests that:

- **Persons with a record of drinking-driving offences may constitute a group in which the likelihood of finding otherwise hidden candidates for alcoholism treatment is higher than in most other groups.**

- **About one-quarter of convicted drinking drivers (representing more than one-quarter of the drinking driving offences because of their offence frequency) may be of a type whose very abnormality tends to immunize them against conventional propaganda or legal sanctions against drinking and driving.**

Regarding the first of these points, it is not intended to suggest that drinking drivers should be referred for treatment instead of letting the present legal sentences take their course. However, driving licences are now being suspended on conviction for these drinking driving offences, and they are being reinstated after certain lengths of time. There seems to be no special reason for re-instatement to be automatic on proof of financial responsibility in the case of repeated offenders. In fact, it is not entirely automatic but is administered with some regard for the driver's probable future driving conduct. It has been suggested therefore that some kind of report from an alcoholism treatment centre should be provided as a guide to those responsible for re-instating such licences.

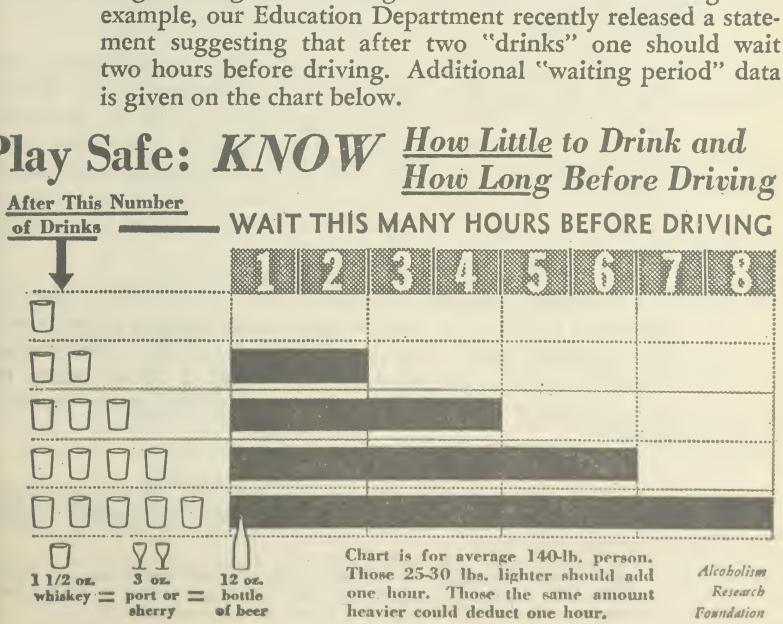
We live in a highly motorized society. Driving is a wellnigh universal activity, which is often quite difficult to avoid: the car can't be left on the street; it has to be taken home. Yet there is about as much sense in telling an untreated alcoholic (who has his car with him) to abstain as there is in telling an

* See footnote on page 5

insomniac to go to sleep. Both are compelled to do what they do by factors beyond their own control.

Further reflection on this matter leads one to question the whole approach of much current safety propaganda and law enforcement intended to discourage driving after drinking—or drinking before driving. The safety propagandists, as well as the police, are hampered by laws which make the offence concerned "impairment" or "intoxication", neither of which appear to be defined with such certainty as, for example, specific rates of excessive speed. Given the uncertainty of being caught (let alone charged and convicted) for impaired driving, it is not surprising that many people who have been drinking, whether alcoholics or normal, simply take a calculated risk and go ahead and drive to where they have to go.

With this in mind, the Foundation has been studying the implications of setting understandable limits which drinkers who are also drivers might be encouraged to follow in governing their driving in relation to their drinking. For example, our Education Department recently released a statement suggesting that after two "drinks" one should wait two hours before driving. Additional "waiting period" data is given on the chart below.



The times given are based on the average length of time it takes to reduce one's blood-alcohol level to .03%, which is a safe limit for practically all drivers. But as mentioned earlier, in this country the offence is not simply one's blood-alcohol level; it is a vague condition known as impairment or intoxication. Most European countries on the other hand define the offence in terms of some specified amount of alcohol in the blood, usually setting the limit somewhat higher than .03%.

Concept of Limits

It may be objected that some people can drive quite safely with higher blood-alcohol concentrations than some proposed limit. This is quite true; yet many who feel they can drive safely (and probably can drive safely) at speeds higher than those posted still accept the speed limit and expect to be prosecuted successfully if they exceed it.

In Great Britain where the statutory offence is much the same as in Canada, the British Medical Association in a recent report[1] states:

"The committee is aware that other considerations will have to be taken into account, not least the question of liberty of the subject, but it is here concerned only with the presentation of the scientific evidence. A compromise would appear to be inevitable between these considerations and the indisputable evidence of the danger to other road users when a car is driven by a person with more than 50 mg./100 ml. concentration of alcohol in the blood."

It seems important therefore that we should study the problems involved in legislating or regulating a corresponding "alcohol limit", and in providing (as the speedometer does for speed) the kind of knowledge a driver needs in order to know when he is, or is not, exceeding such "alcohol limit."[2]

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[1]British Medical Journal, Jan. 23, 1960, page 272. The 50 mg./100 ml. concentration of blood-alcohol referred to is approximately equal to .05% in the terms usually used here, since on average one millilitre of blood weighs 1.05 grams.

[2]A pioneer attempt to develop some way for the average driver to measure his own condition in relation to an "alcohol limit" was the "ALCODIAL", designed and produced some years ago by Dr. J. K. W. Ferguson and Dr. R. Gordon Bell.

Employers Can Help Alcoholics To Seek and Stay In Treatment*

There is always some pressure involved in inducing a patient to seek treatment, whether this pressure be from families, friends, employers or anyone else — not necessarily legal pressure. The greatest potential source of pressure toward treatment lies with employers.

Keeping a good job depends on reliable and efficient performance. Alcoholism or problem drinking results in frequent absenteeism, lateness, spoilage, accident-proneness, irresponsibility, irritability, and general inefficiency on the job.

Recommended Policies

Of these behaviors, only absenteeism has been estimated in relation to alcoholism. Estimates range from 18 to 22 days per year. Average Canadian absenteeism for all causes has been estimated at just over 8 days. The excess absenteeism of the alcoholic then is roughly 10 days per year, or two weeks' work. Management can profitably help such alcoholics recover:

- by setting basic policies which make continuation of a problem employee's job conditional on his getting help with his drinking problem.
- by suggesting some sources of help, preferably more than one, e.g. company doctor, personnel counsellor, outside clinics, family doctor, A.A.
- by supporting referral by continuing to view problem drinking as an illness rather than simply poor behaviour. (In some companies this is demonstrated by eligibility for sick benefits.)
- by tolerating relapses only if the employee continues in treatment.
- by reserving final possibility of discharge at least until treatment has been undertaken and continued for some months without noticeable improvement.

Need Communication

To be effective, these policies must be communicated to all concerned through interviews or meetings with department

* See footnote on page 5

heads, supervisors, union personnel and through employee papers, posters, literature. The alcoholic employee must first of all be recognized as such. Here are some clues: frequent Monday, post-holiday and post pay-day absences; erratic work, incomplete assignments, moodiness and unusual or increasing sensitivity; frequent minor illness excuses, apparent personality changes, reports of domestic discord, financial troubles; aroma of alcohol, hand tremor, gaps in memory, and drinking habits differing from those of companions, e.g., faster drinking, going on longer, habitual heavy spending on drink, tending to drink alone, and morning drinking. Once recognized the alcoholic needs:

- understanding, but not coddling or covering up.
- clear, undeniable notice that his drinking is visibly affecting his job performance and consequently is the legitimate concern of his employer and fellow workers.
- encouragement in seeking help from the company doctor (often the best way is for the foreman or supervisor to accompany the employee to the doctor's office).
- proof that the company will continue to employ him on condition that he is making a conscientious effort to use the help that is available to alcoholics in plant or community.

Earliest Signs

The earliest signs of impending alcoholism need to be more widely known. If everyone could become able to recognize them, it would be a tremendous step forward toward preventing the development of alcoholism in countless individuals.

Treatment Administration Trends Discussed by Medical Director*

Whatever the total number of alcoholics existing in Ontario, several thousand of them now seek treatment through various resources. Further public education and perhaps some changes in legislation will bring more demand for treatment in the future.

The desire for treatment may be brought on by: (a) recognition of one's own alcoholism or alcohol addiction; (b) some physical or psychiatric complication of alcoholism; or (c) some pressure brought by the family, employer or court.

Within Community

As with any other illness, alcoholism can be handled initially by the family doctor as a general medical problem. Many cases should respond to his management; one of the Foundation's tasks therefore, is to be a source of help to the general practitioner. During 1959 the Foundation put on its first 1½-day course for such physicians. Similarly, it continues to provide some knowledge to groups from other interested professions, such as social workers, nurses and the clergy.

The general practitioner needs general hospital facilities (usually just for a few days) to get his patient through the most acutely distressing stage. Our impression is that more and more (though not all) local hospitals are admitting the acutely ill alcoholic.

Role of Special Clinic

On the other hand there are chronic cases, sometimes without clear physical complications, which require more time in hospital, and it is these who should be referred to the special clinic for one to four weeks.

There are also some patients who require even longer hospital care, including those more seriously ill patients who are now eventually admitted to mental hospitals. Families, however, are often reluctant to arrange for this last, often doing so

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* Medical Director of the Alcoholism Research Foundation is John D. Armstrong, M.D. This article is condensed from his report in the Foundation's Ninth Annual Report.

only when imperative in order to save the life or mental integrity of the patient or to prevent further serious harm to the family.

It is hoped that as more and better treatment becomes available there will be less delay in bringing various types of known cases under care.

Hospital Trends

General hospital admissions of patients from the Foundation dropped sharply in 1959, despite the apparent increase, mentioned earlier, in the number of hospitals willing to take some alcoholic patients. This is partly because of increasing demands for hospital beds generally, as a result, in part, of more widespread hospital insurance, and partly because there are now more sources outside the Foundation which are getting alcoholics into hospitals.

In the Foundation's own in-patient clinic total admissions have remained the same as previous years but total days spent in the clinic have gone up about 9 percent. This is because we have been encouraging longer stays where indicated. Also there has been an increase in the numbers admitted to the Foundation's in-patient service without any prior short period in general hospital.

There has been a slight but general increase in out-patient activities through the year. Since we have no impression that the number of patients coming to us in an acutely ill state has decreased, we must conclude from the above trends that more of the acutely ill patients are now being handled on an out-patient basis, some being later admitted to the Foundation's in-patient clinic but others continuing as out-patients.

Rehabilitation

There continues to be considerable emphasis in the area of social rehabilitation. This begins while the patient is still in hospital and occurs as a direct result of the fact that many of the treatment activities deal with the patients on a group basis. Later, when the patient leaves hospital he may continue in groups. These are primarily psychotherapeutic in nature, but there are also various activities available to encourage and develop new social relationships and recreational skills. Many of our patients can be helped to do this, as part of their relationship to the clinic, long before they are able to establish such relationships in the community at large.

The Foundation's Toronto clinic now has to be moved to temporary premises on the site where the Foundation's new quarters are to be built. The experience gained in the past few years is playing an important part in planning the larger, more efficient and more diversified facilities which we hope to have available in a few years.

Our clinics continue to provide field training opportunities for graduate students in various fields, particularly psychiatry and social work. In addition there has been some increase in under-graduate medical teaching on the subject of alcoholism. It is gratifying to see that in at least two cases doctors who attended our clinic during their post-graduate training have played a leading part in starting special services for alcoholic patients in certain Ontario hospitals.

Review Branch Outpatient Services*

Treatment at the branches is essentially an out-patient service, supplemented by arrangements for initial short term hospitalization in local general hospitals where necessary. Occasionally also branch patients may go for two or three weeks to the in-patient clinic at Toronto before returning to the branch area for follow-up on an out-patient basis.

Branch out-patient treatment includes medical and psychiatric assessment, medications, individual psychotherapy, group and social therapy, introduction to Alcoholics Anonymous and counselling services for the relative of alcoholic patients.

London Branch, from its inception in 1954 has been service oriented. The emphasis in treatment is on individual psychotherapy which, during the last year, was carried on by the executive secretary (clinical psychologist), the clinical director (a physician), the social worker and the resident in psychiatry.

Ottawa branch treatment orientation has been medical-psychiatric. The executive secretary in his report refers to the

* This article is a portion of the section of the Ninth Annual Report dealing with the role of branches in the activities of the Alcoholism Research Foundation. The original section was prepared by Wm. J. Wacko, M.S.W., the Foundation's Assistant Executive Director, based on reports from branch executive secretaries, Charles H. Aharan, M.A., (London), John A. Neilson, M.S.W., (Ottawa), and Gordon M. Patrick, B.A., (Hamilton).

SUMMARY STATISTICS OF ALL BRANCHES

	Toronto	London	Ottawa	Hamilton	Total
Total number of different cases seen	979	225	201	124	1,529
Less:					
Patients from previous years	463	102	69	20	654
New Patients in year	516	123	132	104	875
Sex:					
Male	412	110	117	99	738
Female	104	13	15	5	137
	516	123	132	104	875
Residence:					
Local	410	85	109	91	695
Out of Town	106	38	23	13	180
	516	123	132	104	875
Referral Source:					
Alcoholics Anonymous	53	39	15	16	123
Family & Friends	83	22	32	12	149
Physicians	122	24	30	11	187
Self-referral	77	8	9	23	117
General Hospitals & Clinics	41	1	5	5	52
Agencies	43	13	7	16	79
Courts, Lawyers & Reform	19	3	3	11	36
Employers & Industry	22	—	5	—	27
Other Patients	28	11	3	5	47
Clergy	12	—	—	4	16
Publicity	4	1	1	—	6
A.R.F. Branches	12	1	1	1	15
Civil Service	—	—	21	—	21
	516	123	132	104	875

branch as an "out-patient clinic and education centre concerned with alcoholism". Apart from the short term hospital treatment available at the Ottawa General and Ottawa Civic hospitals, most of the out-patient treatment during the year was carried on by the Clinical Director, the Executive Secretary, a Psychiatric Social Worker, and a consulting psychiatrist who handled the evening group therapy sessions.

Hamilton branch, being the youngest of the three, is still in the process of evolving its philosophy and approach to treatment. Its essential orientation is to consider alcoholism as a medical problem. This thinking is reflected in the location and arrangement of its office facilities and, for example, by having a nurse in the traditional uniform receiving patients.

Outline Approach and Future Plans For Preventive Education Work*

There is a great deal more to the prevention of alcoholism through public education than repeating an infinite number of times and in a variety of ways such statements as "Alcoholism is an illness — watch out for it", or "Don't drink too much". It is very unlikely that a magic word formula or an educational gimmick will be developed to make the prevention or the early arrest of alcoholism quick and easy. What is required is a growing, long-range program of citizen education and community involvement to accomplish these two purposes.

Professional and Public

General targets for the Foundation's education work are two: members of the several professions which have a direct role in the alleviation and control of alcoholism; and all other members of the general public. Where interest exists, information has to be transmitted to these men and women; and where interest has not yet been awakened it has to be stimulated by appealing to other existing areas of interest and relating these to the question of alcoholism and/or dangerous pre-alcoholic drinking patterns. (Specific suggestions as to how this can be accomplished for nine practical population groupings are

* **Director of Education of the Alcoholism Research Foundation is Robert R. Robinson. He has condensed this article from his full report in the Foundation's Ninth Annual Report.**

spelled out in tabular form on pages 17 to 19 of the Ninth Annual Report and summarized below.)

The Foundation is continually reaching young people through youth groups both inside and outside the school system; it is circulating material to employers, employees and union personnel; it is working in seminars and lecture series with physicians, nurses, social workers, hospital administrators, members of the clergy, and high school teachers; and certainly much of its printed material and many of its films are being seen by alcoholics themselves and by members of their families. Interested persons among the general public are being reached sporadically through the mass media — radio, television, motion pictures, newspapers, and magazines — but the size of the education budget to date has precluded sustained efforts in any of these fields.

Productive Pilot Plan

In a sense, the education department has been developing and testing a pilot plan for the reduction of ignorance and misinformation which persists among many Ontario people of all ages with respect to the dangers inherent in habitual excessive use of alcoholic beverages. And, along the way, the Foundation's education work (including notable contributions from administration, treatment, and research personnel of the organization) has added materially to public understanding of alcoholism, has facilitated recognition of many cases in early stages, and has indicated where and how treatment and rehabilitation can be found.

The education staff creates and distributes printed materials and films, makes speeches, and conducts workshops for special interest groups; and, on the basis of experience, believes that its most successful efforts have been in the latter field. Its annual clergy workshop arranged in cooperation with the Canadian Council of Churches is a good example. The 1959 workshop comprised a series of seven half-day meetings at weekly intervals and covering medical, psychiatric, social work and relevant aspects of the Foundation's research activities. Response to this and similar workshops for other groups calls for a multiplication of such courses across the province. Budget and staff time considerations have limited the number of such workshops and the degree to which they can be undertaken at a distance from

Toronto headquarters or branch locations; but it is felt there can be very productive expansion in this direction.

Two New Positions

Two new positions have already been created and filled in an effort to render this work more effective—Mr. Alan Marcus, M.A., joined the education staff last fall to undertake investigations into public attitudes toward and understanding of alcoholism; and Miss Betty Kinch, R.N., has been appointed Nursing Instructress with both internal and external teaching duties.

Among projects in various stages of completion at year-end are: a manual for the guidance of secondary school teachers in handling alcohol studies (undertaken at the request of the Ontario Department of Education), a pocket-size reference book on alcohol problems (intended for all who write or speak on related topics), a booklet for teen-agers in comic book format, and a short, dramatic film also aimed at the teen-age level.

Below is a summary of seven population groupings within its province, followed by the focal points of interest considered appropriate in planning messages and selecting media for each group:

A. **Young people (ages 14 to 20).** Focal points of interest in alcohol problems: (1) Physical and psychological effects of various alcoholic drinks likely to be encountered in early experimental use. (2) Effects of drinking on driving ability. (3) Effects of drinking on behavior controls. (4) Significance of drinking in adult society.

B. **Employers and employees:** (1) Effects of heavy drinking and hangover on job performance, absenteeism, accidents, and wage loss. (2) Recognition of alcoholism, treatment possibilities, and the value of rehabilitated alcoholics. (3) Company policies and procedures which have proved effective in

reclaiming deteriorating alcoholic employees. (4) Attitude of labor unions and their co-operation in rehabilitation programs. (5) Instruction of personnel and medical departments and of supervisors in respect to recognizing, counselling, and referring cases or suspected cases for treatment. (6) Company-wide education programs to discourage repeated excessive drinking and to encourage employees with alcohol problems to seek help.

C. All those who drive cars: (1) Effects of drinking on driving ability.

D. All social drinkers: (1) Effects of alcohol in various quantities. (2) Signposts on the road to alcoholism.

E. Alcoholics and their families: (1) Signposts on the road to alcoholism. (2) Community treatment resources — how to approach them, and what to expect when one applies for help.

F. Sellers and servers of alcohol: (1) An appreciation of alcoholism as a problem. (2) A knowledge of the kind of person and the kind of drinking usually involved in alcoholism.

G. Professional health workers: (1) A knowledge of the disorder alcoholism and how it affects the individual man or woman. (2) Community treatment resources and how to use them.

H. Members of the clergy: (1) How to help alcoholics and their families. (2) How to deal constructively with this subject from the pulpit and in various group discussions.

I. Teachers and youth workers: (1) Survey data on the extent of drinking among teen-agers. (2) Material for transmission to teen-agers (see "A" above).

List Research Reports on Alcohol Subjects By Staffs, Students and Grantees of Foundation

Treatment Studies

TITLE	AUTHOR	WHERE PUBLISHED
Effects of Clinical Treatment on Behaviour of Alcoholic Patients: An Exploratory Methodological Investigation.	Gibbins, R.J. & Armstrong, J.D.	Quart. J. Stud. Alc. 18: 429-50, 1957
Historical and Comparative Study of Compulsory Treatment for Alcoholics, with Particular Reference to Ontario.	Schmidt, W.	A.R.F. Substudy 1-4-57
Effects of Cyanamide and Ethanol on Bleeding Weights and Blood Acetaldehyde in Mice and Rats.	Warson, M.D. & Ferguson, J.K.W.	Quart. J. Stud. Alc. 16: 607-13, 1955
Effect of Derivatives of Cyanamide With and Without Ethanol on Bleeding Weights of Rats and Mice.	Ferguson, J.K.W., Maharajh, R.M. & Warson, M.D.	J. Pharmacol. & Exper. Therap. 113: 20-1, 1955
Research Design in the Evaluation of Hypnotherapy.	Paul, J.	J. Clin. & Exp. Hypnosis 6(2): 71-82, 1958
The Use of Lipotropic Factors in the Treatment of Alcoholism.	Armstrong, J.D., Bingham, J.R., Gibbins, R.J., & Kerr, H.T.	Can. Med. Assoc. J. 75: 198-201, 1956
A New Drug For Alcoholism Treatment.	Ferguson, J.D.W., Armstrong, J.D., Kerr, H.T., & Bell, R.G.	Can. Med. Assoc. J. 74: 793-81 1956

The annual report contains (in addition to a review by the Director of Research, John R. Seeley) a complete cross-indexed directory of all research projects undertaken or sponsored by the Foundation since it was established. On succeeding pages of this issue of Alcoholism is a smaller list, extracted from the annual report, of the principal reports on these projects, either published or on file.

TITLE	AUTHOR	WHERE PUBLISHED
Some Comments on the Proposed Habitue Act.	Seeley, J.R.	A.R.F. Substudy 20-1-59
The Protection Client Who Drinks to Excess.	Barnes, J.	M.S.W. thesis, School of Social Work, University of Toronto 1957
The Protective Drugs in the Treatment of Alcoholism.	Armstrong, J.D.	Can. Med. Assoc. J. 77: 228-32, 1957
Psychological and Social Factors in the Rehabilitation of the Alcoholic.	Deschamps, C.	M.S.W. thesis, St. Patrick's College, School of Social Work, University of Ottawa, 1956
A Psychotherapeutic Technique with large Groups in the Treatment of Alcoholics: A Preliminary Report.	Armstrong, J.D. & Gibbins, R.J.	Quart. J. Stud. Alc. 17: 461-78, 1956
A Study of the Relationship Between Drinking Behaviour and Participation in Child Care Activities of a Sample of Alcoholic Patients Before and After Treatment.	Jackson, M.J.	M.S.W. thesis, School of Social Work, University of Toronto 1958
The Relationship Between the Drinking Pattern of Alcoholic Patients and their Employment Pattern Before and After Treatment.	Dastyk, R.	M.S.W. thesis, School of Social Work, University of Toronto 1959. (Studies 17, 32, 37, 62)
The Relation Between Social Participation and Drinking Before and After Treatment in a Sample of Alcoholic Patients.	Schmidt, W.	M.S.W. theresis, School of Social Work, University of Toronto 1957
Observations on the Treatment of the Acute Alcoholic.	Park, A.M. & Bedwell, S.F.	Can. Med. Assoc. J. 75: 406-11, 1956
Description of the Alcoholic		
The First Drink.	Little, D.	M.S.W. thesis, School of Social Work, St. Patrick's College, University of Ottawa, 1959
Admissions of Alcoholics Without Psychosis to Mental Institutions, and the Estimated Prevalence of Alcoholism: Ontario, 1948-55.	Schmidt, W. & Smart, R.G.	Can. J. Pub. Health 50: 431-435. 1959

Alcoholism In Ontario: A Survey of an Ontario County.	Gibbins, R.J.	Quart. J. Stud. Alc. 15: 47-60, 1954
Changes in Brains of Chronic Alcoholics.	Dixon, T.P., Lynch, M.J.G., Raphael, S.S., Mellor, L.D. & Spare, P.D.	A.M.A. Archives of Pathol. In Press
Chronic Alcoholism and Alcohol Addiction: A Survey of Current Literature.	Gibbins, R.J.	Brookside Monograph No. 1, 57pp. Toronto: A.R.F. & U. of Toronto Press 1953
How Ontario Clergy Look at Alcoholism	Wolch, C.	Alcoholism Research, 4(4): 1-7, 1957
A Note on Alcoholics and Drunk Driving.	Schmidt, W. & Smart, R.G.	Criminal Law Quarterly 1: 419-422, 1959
The Ecology of Alcoholism: A Beginning. In: Society, Culture and Drinking Patterns.	Seeley, J.R.	D.J. Pittman & C.R. Snyder (Eds) N.Y.: Wiley & Son. In Press
Alcohol and Experimental Neurosis in Cats: Some Ruminations.	Vogel, M.D.	A.R.F. Substudy 1-6 & 7-59
Factors in the Background of the Imprisoned Chronic Inebriate.	Lacey, W.R.	M.S.W. thesis, School of Social Work, University of Toronto 1952
Fat Embolism in Chronic Alcoholism.	Dixon, T.P., Lynch, M.J.G., Raphael, S.S., Mellor, L.D. & Spare, P.D.	A.M.A. Archives of Path. 67: 68-80, 1959
Alcohol, Alcoholism and Introversion-Extraversion.	Vogel, M.D.	Can. J. Psycho. 13: 76-83, 1959
Alcoholism and the Personality Dimension of Introversion-Extraversion.	Vogel, M.D.	A.R.F. Substudy 4-6-58
Introversion-Extraversion in an A.A. and a Clinic Group of Alcoholics.	Vogel, M.D.	A.R.F. Substudy 5-6-59

TITLE	AUTHOR	WHERE PUBLISHED
Introversion-Extroversion and Conditioning in Alcoholic Subjects	Smart, R.G.	M.A. thesis, Dept. of Psychol., University of Toronto
Studies in the Epidemiology and Ecology of Liver Cirrhosis Mortality.	Seeley, J.R. & Schmidt, W.	1-1 & 4-58 to 1.6-1 & 4-59
Low Blood Alcohol Concentrations, Personality Adjustment, and Frustration Related to Psychomotor Performance.	Murray, J.	M.A. thesis, Dept. of Psychol., University of Toronto 1958
Measuring Hostility In Alcoholics.	Egener, K.C.	M.A. thesis, Dept. of Pschol., University of Western Ontario 1953
Misdemeanants: Inebriate and Non-Inebriate.	Seeley, J.R.	A.R.F. Substudy 8-1-58.
Personality Syndromes in Chronic Alcoholism: A Factorial Study.	Clark, J.W.	Ph.D. thesis, Dept. of Psychol. Queen's University 1958
Three Preliminary Studies of the Psychoanalytic Theory of Alcohol Addiction.	Gibbins, R.J. & Walters, R.H.	Quart. J. Stud. Alc. In Press
An Exploratory Study of the Psychoanalytic Theory of Alcohol Addiction	Vogel, M.D.	A.R.F. Substudy 6-6-59
Serum-Magnesium and Corticosteroids in Chronic Alcoholism.	Raphael, S.S., Dixon, T.P., Lynch, M.J.F., Mellor, L.D. & Spare, P.D.	The Lancet, Sept. 12, 1959, pp. 355-356
Some Social and Cultural Aspects of Alcoholism.	Popham, R.E.	Can. Psychiat. Assoc. J. 4: 222-229, 1959
Statistics of Alcohol Use and Alcoholism in Canada 1871-1956: First Report. Toronto.	Popham, R.E., Schmidt, W. et al.	A.R.F. & University of Toronto Press 1958, 155 + xv pp.
Further Studies in Chronic Alcoholism.	Dixon, T.P., Lynch, M.J.G., Raphael, S.S., Mellor, L.D. & Spare, P.D.	Can. Med. Assoc. J. In Press

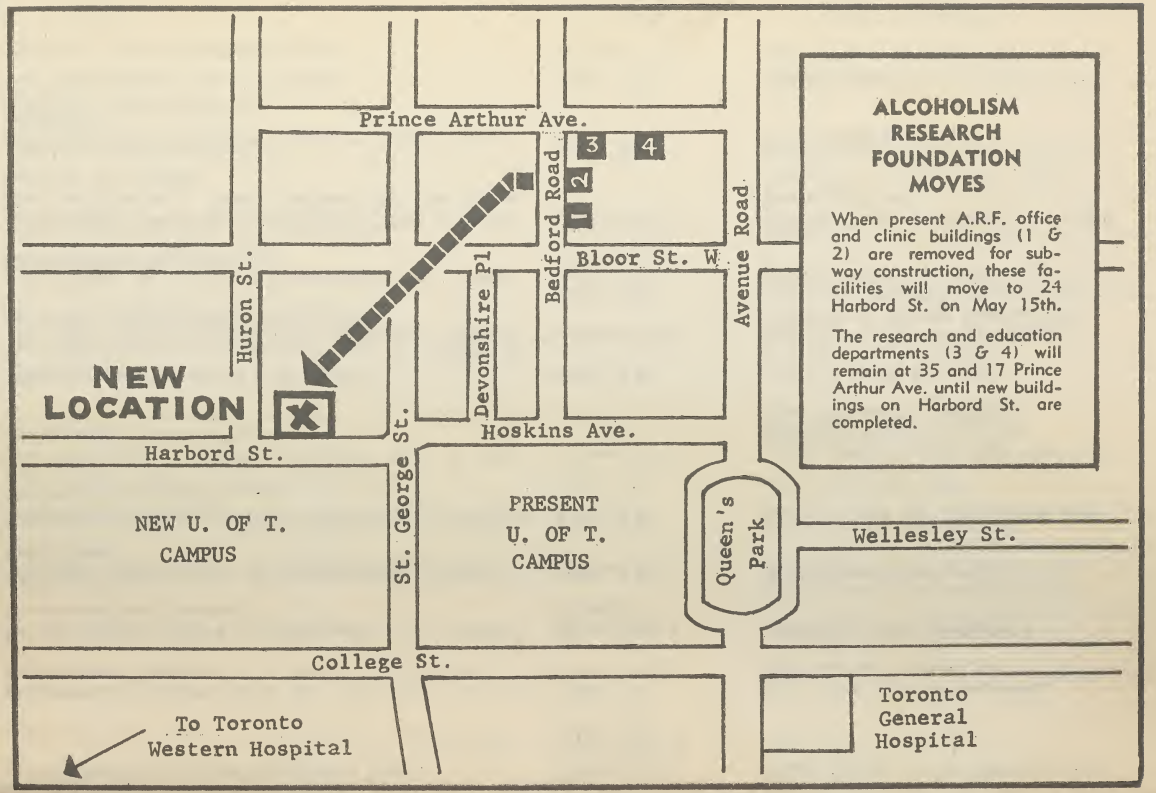
Alcoholism and Traffic Accidents: A Preliminary Study.	Popham, R.E.	Quart. J. Stud. Alc. 17: 225-32, 1956
Alcoholics, Drinking and Traffic Accidents.	Schmidt, W. & Smart, R.G.	Quart. J. Stud. Alc. 20: 631-644
Undersocialization in the Incarcerated Alcohol Addict.	Gibbins, R.J.	M.A. thesis, Dept. of Pschol., Queen's University 1952
Young Adult Drinking Habits.	Stern, W.I.	M.S.W. thesis, School of Social Work, University of Toronto 1952

Description of Alcohol Use

Alcohol: Act and Attitude, Some Preliminary Explorations.	Seeley, J.R.	A.R.F. Substudy 9-1-58
Alcohol Act and Attitude: A Revision.	Seeley, J.R.	A.R.F. Substudy 9.1-1-59
The Influence of Alcohol on Carbohydrate Metabolism in the Liver and in Isolated Diaphragms.	Clarke, D.W. & Evans, R.L.	Quart. J. Stud. Alc. In Press
Drinking Patterns in an Industrial Society.	Pullman, D.R.	Ms. on file, A.R.F. 1954
Effect of Insulin on Ethanol Metabolism.	Masoro, E.J. & Abramovitch, H.	Can. J. Biochem. & Physiol. 32: 465-9, 1954
Alcohol in the Iroquois Dream Quest.	Carpenter, E.S.	Amer. J. Psychiat. 116: 148-151, 1959
Low Blood Alcohol Concentration and Psychological Adjustment as Factors in Psychomotor Performance.	Vogel, M.D.	Quart. J. Stud. Alc. 19: 573-589, 1958
Metabolism of C14 Ethanol by Surviving Rat Tissues.	Masoro, E.J., Abramovitch, H. & Birchard, J.R.	Amer. J. Physiol. 173: 37-40, 1953
The Influence of Ethyl Alcohol on the Oxygen Uptake of Cerebral Slices.	Clarke, D.W. & Evans, R.L.	Can. J. Biochem. & Physiol. In Press

TITLE	AUTHOR	WHERE PUBLISHED
Study of a Prison Aggression Group.	Henheffer, B.W.	M.A. thesis, Dept. of Psychol., Queen's University 1952
Methodological Studies		
"Alcoholism Is A Disease."	Seeley, J.R.	Society, Culture & Drinking Patterns. D.J. Pittman & C.R. Snyder (Eds.) N.Y.: Wiley & Son. In Press
Alcohol-Epilepsy Link Still Uncertain.	Smart, R.G.	Alcoholism 5 (1): 17-20, 1958
The Alcohol Language.	Keller, M. & Seeley, J.R.	Brookside Monograph 2, 32pp. Toronto: A.R.F. & University of Toronto Press 1958
The Association Between Motivation for Seeking Treatment and Treatment Outcome in a Sample of Alcoholic Patients.	Neilson, J.A.	M.S.W. thesis, School of Social Work, University of Toronto 1956
Attitudes to Drinking Alcoholic Beverages: An Attitude Scale.	Bell, S.E.	M.A. thesis, Dept. of Psychol., University of Toronto 1955
A Preliminary Note on Drinking and Mating.	Seeley, J.R.	A.R.F. Substudy 1-1-57
A Search for Drugs with Disulfiram-Like Activity.	Boyd, E.M.	Quart. J. Stud. Alc. In Press
A Critique of the Genetotrophic Theory of the Etiology of Alcoholism.	Popham, R.E.	Quart. J. Stud. Alc. 14: 228-37, 1953 U. of Toronto (Pharmacology) 1953
How Many Alcoholics?—Under Review.	Seeley, J.R.	Alcoholism 6 (3): 7-8, 1959
The Jellinek Alcoholism Estimation Formula and its Application to Canadian Data.	Popham, R.E.	Quart. J. Stud. Alc. 17: 559-593, 1956
The Keller-Annals, 1958, Definition of Alcoholism.	Seeley, J.R.	A.R.F. Substudy 4.2-1-59
"Looking Backward on Alcoholism".	Seeley, J.R.	A.R.F. Substudy 12.3-1-58

A Critique of the Manson Evaluation Test.	Gibbins, R.J., Smart, R.G. & Seeley, J.R.	Quart. J. Stud. Alc. 20: 357-361, 1959
Polyethylene Plastic Bags As Containers for Air Containing Ethanol.	Salem, H.	M.A. thesis, Dept. of Pharmacol., University of Toronto 1955
Review Present State of Knowledge on Alcohol, Alcoholism and Driving.	Smart, R.G. & Schmidt, W.	Alcoholism 5 (4): 17-22, 1958
Alcoholism Prevalence: An Alternative Method of Estimation.	Seeley, J.R.	A.R.F. Substudy 19-1-59
Estimating the Prevalence of Alcoholism: A Critical Analysis of the Jellinek Formula.	Seeley, J.R.	Quart. J. Stud. Alc. 20: 245-254, 1959
Some Problems of Alcohol Research From A Social Anthropologist's Point of View.	Popham, R.E.	34-38 (English), 1959. Reprinted in: Alcoholism 6 (2): 19-24, 1959 Alkoholpolitik 1: (Swedish)
"Programming" Research in Alcoholism.	Seeley, J.R.	A.R.F. Substudy 12.1-1-58
The Q-Technique as a Possible Means of Differentiating Alcoholics from Non-Alcoholics.	Aharan, C.H.	M.A. Thesis, Dept. of Psychol., University of Western Ontario 1952
The Problem of Research Progamming: A Prefatory Note on the Model for Planning.	Seeley, J.R.	A.R.F. Substudy 12-1-59
A Preliminary Examination of the Applicability to Finnish Mortality Data of a Trend Method for the Estimation of "P" Values.	Popham, R.E.	Publicts. Finnish Foundation for Alcohol Studies, In Press
Alcoholism and Vehicle and Non-Intervehicle Traffic Accidents.	Seeley, J.R.	A.R.F. Substudy 10-1-58
The W.H.O. Definition of Alcoholism.	Seeley, J.R.	Quart. J. Stud. Alc. 20: 352-356, 1959


Prince Arthur Ave.
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Bedford Road
Bloor St. W.
Avenue Road
Huron St.
Devonshire Pl
NEW LOCATION
Hoskins Ave.
Harbord St.
St. George St.
NEW U. OF T. CAMPUS
PRESENT U. OF T. CAMPUS
Queen's Park
Wellesley St.
College St.
To Toronto Western Hospital
Toronto General Hospital
ALCOHOLISM RESEARCH FOUNDATION MOVES
When present A.R.F. office and clinic buildings (1 & 2) are removed for subway construction, these facilities will move to 24 Harbord St. on May 15th.
The research and education departments (3 & 4) will remain at 35 and 17 Prince Arthur Ave. until new buildings on Harbord St. are completed.

alcoholism

RESEARCH

TREATMENT

EDUCATION

Vol. 7, No. 2 Summer, 1960

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This periodical is published four times a year in the interests of a deeper understanding of the widespread disorder alcoholism.

Each issue contains pertinent, factual information selected primarily because of its interest to those who are called upon to deal with alcoholism professionally. Articles published do not necessarily represent the views of the Foundation.

If you would like to receive this publication regularly, or if you wish additional information about some aspect of alcoholism, you are invited to write to the Alcoholism Research Foundation, Education Department, 17 Prince Arthur Ave., Toronto 5, Ontario (WA. 5-8951)

There are also branch offices at:
155 James St. South, Hamilton (JA. 7-4941)
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1206 Bank St., Ottawa (RE. 3-8343)

Edited by Vernon H. K. Lang

Circulation of this issue: 11,

Vol. 7, No. 2
Summer, 1960

alcoholism

RESEARCH

TREATMENT

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Explore Body's Mechanism of Thirst

By HAROLD KALANT, M.D., B.Sc., PH.D.*

WITH the arrival of hot weather, and the season of dripping brows and long cool drinks, it is timely to devote a few lines to the subject of thirst — what it means, how it is produced, what effect alcohol has upon it.

As most people now know, the human body is composed of billions of minute cells, each of which is comparable in many ways to the tiny one-celled organisms living in the lakes and oceans of the world. In the large multi-cellular animals, including man, each cell in the body continues to live in, and depend upon, the watery environment surrounding it. To that extent, therefore, we can think of the human body as a collection of billions of individual cells floating in a lake of blood

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*Dr. Kalant is Assistant Research Director (Biological Studies) of the Alcoholism Research Foundation.

and tissue fluid, contained inside a water-tight skin. The exact composition of the "lake" of blood and tissue fluid must be kept extraordinarily constant, or the cells will sicken and die.

An important aspect of the composition of this "lake" is the proportions of water and various mineral salts which it contains. Normally, these proportions are kept very constant. The amounts of water and salts taken in by mouth are just balanced by the amounts lost in the urine, the sweat, and the breath. If too much is taken in, healthy kidneys can dispose of the excess by putting out more. If too little is taken in, or if too much is lost (as by excessive sweating), the kidneys decrease their output or even, in extreme cases, stop altogether. At the same time, if the deficiency is not corrected, water is gradually drawn out of the cells into the drying-out "lake" in which they live. It is this loss of water from the cells, known as *intracellular dehydration,* which gives rise to the sensation of thirst.

Felt in Mouth and Throat

The particular cells which produce the feeling of thirst are the nerve endings in the membrane lining the mouth and throat. If they are touched with local anaesthetic, no thirst will be experienced even though the body is definitely short of water. The dehydration of these nerve cells may sometimes arise from purely local causes, such as prolonged mouth-breathing, or eating a mouthful of dry food. Such superficial thirst is easily satisfied by a sip of water, just enough to moisten the membrane. On the other hand, the real deep-down thirst of a hot summer day results from intra cellular dehydration, which as explained above, affects all the body's cells including, incidentally, those in the nerve endings of the mouth and throat.

Need Salt Too

Sweat, as every one knows, is salty. Heavy sweating means quite a considerable loss of salt from the body, in addition to the water loss. Replacement of the water alone, without the salt, causes the "lake" of blood and tissue fluid to become too dilute, giving rise to a different type of disturbance, the well-known severe muscular cramps. For this reason, the thirst provoked by heavy sweating should be remedied by extra intake of salt as well as water. For most people, a little extra salt in the food is enough to take care of this. In foundries, mines, boiler rooms, and other places where the problem is much more severe, it is

necessary to provide salt tablets, or to put very dilute salt-water in the drinking fountains.

Other Ingredients, Temperature?

Other ingredients of a drink have little or nothing to do with actual relief of thirst. Carbonated drinks for example, may please our taste sensation more than "flat" drinks, but they are no more effective for correcting dehydration.

Similarly, the choice of hot vs. cold drinks is purely a matter of taste. In fact, there is very little sense in the belief that a hot drink is more cooling than a cold one. On a hot day, the blood vessels in the skin are fully dilated, and heat loss from the body is proceding as rapidly as possible. Under these conditions, a hot drink simply contributes more heat to the body.

Sweet drinks tend to be less satisfactory than sour ones, because of their local effect in the mouth and throat. The sugar remaining on the mucosal surface exerts what is known as an *osmotic effect,* tending to draw water out of the cells, causing local dehydration and thus causing a renewal of the sensation of thirst.

Role of Alcohol?

Where does alcohol fit into the picture?

One thing is certain — that the only benefit which the dehydrated person receives from a beer or a Tom Collins, etc., is from the water contained in the drink. Alcohol itself is of no benefit in the correction of dehydration. If anything, it may make it a little worse.

Straight liquor, containing 40% or more of alcohol, is irritating to the cells of mucous membranes or tissues. Probably most men have experienced the burning sensation caused by alcoholic after-shave lotions on a cut or scraped face. Similar irritation is produced by straight liquor in the stomach. If one were to gargle with straight liquor instead of swallowing it directly, the same effect would be produced in the mucous lining of the throat, and the resulting temporary damage to the nerve cells might cause enough local anaesthesia to reduce thirst. However, this would be a very poor way to treat the dehydration which caused the thirst.

Alcohol under certain circumstances is a diuretic, a substance which can temporarily impair the ability of the kidney to

conserve water. Therefore, when slight dehydration might normally cause the kidney to slow down its output of water, alcohol may in some cases prevent this protective measure, and so exaggerate the dehydration. Obviously, therefore, true thirst is no reason for taking alcohol. As a correction for dehydration, a lemonade beats a Collins every time.

Tuberculosis and Alcoholism Challenge for Joint Research

IS ALCOHOLISM a problem affecting TB control or is TB something that affects the control of alcoholism? The two disorders are often found together in the same patient. So far, no one has yet demonstrated a causal relationship one way or the other. Yet the treatment of either illness is often complicated by the presence of the other.

Much of the literature suggests that the proportion of alcoholics among TB sanatoria patients is increasing. It is difficult to document any such trend in actual figures, partly because the authorities in TB hospitals have not always used consistent criteria in defining or diagnosing those whom they felt to be alcoholics. In different studies, even at about the same period of time, the proportions of alcoholics reported in TB institutions (in various parts of the world) have ranged all the way from 4% to over 50%. Even the lowest of these figures, however, is somewhat higher than the estimated prevalence of alcoholism in Ontario's adult population.

There are two Ontario studies which throw some light on the extent of this problem.

Dr. C. A. Wicks[1], in a paper discussing 500 consecutive admissions to the Toronto (Weston) Hospital for Tuberculosis, says that 4.2% of those admitted who were found definitely to have tuberculosis were also diagnosed as chronic alcoholics (20 out of 471).

Josephine Chaisson[2], in a study of "Irregular Discharges from Ontario Sanatoria", found that 25% of those

who left sanatoria against medical advice showed evidence of or a history of alcoholism. In the same study, a small sample of "regular" discharges (on medical advice) showed 10% having the same evidence of alcoholism. If we relate these two proportions to the overall numbers receiving the two types of discharge from sanatoria it appears that roughly 12% of those leaving sanatoria would be expected to be alcoholics. This is about six times the prevalence expected in the adult population as a whole.

There are several ways in which treatment for tuberculosis in the alcoholic is complicated by the presence of alcoholism.

1. Often TB in alcoholics is recognized only at a more advanced stage than with other patients.
2. By the time a patient reaches the sanatorium, his drinking may well have led to malnutrition, unhygienic modes of living and generally poor health.
3. The social deterioration of some alcoholics may hamper staff relationships with all alcoholic patients in a sanatorium.
4. Drinking behaviour may disrupt hospital routine and personal relationships.
5. Gastric complications of alcoholism may lead to poor tolerance of antibiotic drugs which have become so important in TB treatment.
6. Both physically and emotionally the alcoholic may be less able to undergo major treatment operations, may refuse some treatments and/or avoid them through absences and early termination.
7. Poor environment after discharge may hamper rehabilitation and contribute to relapses.

The prospect of successful treatment of TB in the alcoholic is therefore to some extent dependent on successful recognition and treatment of the patient's alcoholism. The patient finds himself in a sanatorium where the staff are for the most part trained to deal with TB patients only, making it unlikely that his alcoholism will receive first consideration: yet this omission may well contribute to failure of treatment for TB.

What Can Be Done?

In some institutions attempts have been made to provide special assistance for the alcoholic TB patient at the rehabilitation stage, immediately before discharge back into the community. While this may be a constructive approach to helping the patient go back to the community free of his alcoholism, it fails to be of much help to the treatment personnel who tried to deal with his tuberculosis.

On the other hand, a much earlier start might greatly facilitate not only recovery from alcoholism but also recovery from TB. Such an earlier start, however, presupposes some knowledge and understanding of alcoholism on the part of the TB hospital staff. Such knowledge and understanding might tend to remove some of the moralistic feelings about drinking and drunkenness that so often prevent a useful clinical approach to alcoholism.

The alcoholic needs help in dealing with something that he cannot control himself. Condemnation and punishment not only fail to provide help, they actually hinder recovery from most forms of alcoholism by intensifying the guilt feelings which so many alcoholics can only allay through more drinking. On the other hand, absence of a condemnatory attitude (either expressed or simply sensed by the alcoholic) does not imply that one should supinely tolerate patients' drinking behaviour. As it is frequently put, one should neither condemn nor condone.

Just how to tread this straight and narrow path is a clinical art which is learned mainly through experience. Properly supervised time spent in alcoholism clinics might well be a worthwhile short experience not only for the physicians of TB hospitals but also for the nurses and rehabilitation personnel — at least for those with supervising and teaching responsibilities.

One of the earliest results of increased knowledge of alcoholism will be to enable someone around the TB hospital to distinguish between alcoholism and mere mischievous behaviour. Recognition of truly alcoholic behaviour is an important aspect of diagnosis. Having recognized it, then the proper atmosphere must be maintained that will help the alcoholic himself to recognize his alcoholism. This can help motivate him toward treatment.

Treatment itself can take many forms, but it is inevitable that they should be integrated with other aspects of the institution's management of the patient concerned. At least one important aspect of alcoholism treatment, removal of the supply of alcohol, is for the most part automatically dealt with by the patient's residence in hospital for an extended period. However, much of the burden of complaint from sanatorium staffs about alcoholic patients revolves around periods of leave, from which patients sometimes return intoxicated.

If the patient concerned has become interested in treatment for his alcoholism while in the hospital, there are ways of dealing with this problem of relapses while on leave. For example, one of the newer protective drugs, Temposil (CCC), which was developed by research financed by the Alcoholism Research Foundation, may be useful. While the alternative drug, Antabuse, takes several days to sensitize the patient, Temposil does this in 2-3 hours and protects the potential drinker for 2-3 days — just about enough to cover a weekend. It should only be used, of course, with the patient's full understanding and consent.

Not all alcoholism treatment is clinical or medical. Alcoholics Anonymous can be and is very effective in some institutions. An effective introduction to AA inside the TB hospital may very well build the foundations of an ongoing link with a part of the outside community which can greatly help to rehabilitate those who are discharged. But AA, if it is to make its most effective contribution, needs to be backed up by supportive attitudes toward it on the part of the hospital staff.

It is not intended here to suggest that TB hospitals should suddenly shift their primary goals from TB treatment to alcoholism treatment. This could not and should not be done. However by successfully coping with alcoholism among TB victims, TB control personnel appear likely to improve their chances of success in dealing with a noticeable proportion of their TB patients.

Research Goal

Dr. Joan Jackson[3] has suggested that the most workable treatment goal in this field is a research goal. The risks of staff becoming disillusioned or discouraged, on insufficient

evidence as to the effects of the program, can be minimized, she suggests, if the goal is simply to find out which treatments work best for tuberculous alcoholic patients. This of course presupposes that there will be a control group of alcoholic patients receiving no special treatment, as well as others who receive some other prescribed management. The observed results of continuing comparison of the two groups could do as much to teach TB hospital staff how to deal with this problem as could any amount of special lecturing by imported specialists.

Problem Not Decreasing

Drugs developed over the past two decades have done much to change the whole character of tuberculosis treatment. Length of hospitalization has shortened and home treatment has become more possible. Waiting lists have disappeared and vacant beds have become available.

Case-finding techniques have improved and have moved into new areas, as for example the routine X-raying of those who pass through Ontario's larger prisons, a group where the ratio of cases to examinations has been 12 times as high as in mass surveys.[4] It seems certain that as TB case-finding programs move into other TB-prone groups, they will corral at the same time a great many alcoholics. The problem of the alcoholic in the TB hospital therefore is unlikely to decrease.

The Alcoholism Research Foundation routinely provides short orientation sessions on alcoholism for interested professional people, such as physicians, clergymen, social workers, nurses and others. Personnel of those TB sanatoria where alcoholism seems to be a problem could take advantage of the Foundation's availability for suitable professional training efforts. At the same time there is a need for more research into treatment of the tuberculous alcoholic. Much of this can only be done within the tuberculosis hospitals themselves.

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A.R.F. Activity News

SUMMER 1960

Foundation Develops Short "One Point" Films

The Education Department of the Alcoholism Research Foundation is now in the process of developing a series of 3-5 minute educational films on alcohol-related subjects. Each of these is to deal with only one item of information. Dramatic techniques are being employed. So far, two such films have been produced, as follows:

Margin for Safety. Focuses attention on time required to eliminate enough alcohol from a person's system before driving.

Hospitality. Gets across desirability of always offering non-alcoholic drinks whenever alcoholic drinks are being served.

Prints of these are available on loan for group or TV showings in Ontario.

Will Repeat Seminar for Physicians

The College of General Practice of Canada will again this fall collaborate with the Alcoholism Research Foundation to present a short seminar course for physicians, especially those in general practice or in public health work. Prompted by the success of a similar 1½-day course held last fall, arrangements are now complete for a two-day course to take place Friday and Saturday, November 18th and 19th at the Foundation's clinic, 24 Harbord Street, Toronto.

Attendance at this seminar, which qualifies members of the College of General Practice for 12 hours of Category I studies, is limited to 25 physicians.

Alcohol and Safety Group Meets in Toronto

In late May one section of a technical scientific conference on research in the field of alcohol and motor vehicle traffic held a one-day research conference in Toronto. The main working paper was presented by Dr. Wolfgang Schmidt, Research Associate of the Alcoholism Research Foundation.

Others present were Dr. Seymour Geisser of Iowa State University Department of Statistics, Dr. William Haddon Jr. of the New York State Health Department Driver Research Center, Dr. Herbert H. Jacobs of the (Stamford, Conn.) Public Service Research Institute, and Dr. Harrison Trice of Cornell University Industrial and Labour Relations School.

Director Attends Stockholm Conference

H. David Archibald, Executive Director of the Alcoholism Research Foundation, has been invited to present the opening address at the section on Alcohol Consumption and Alcoholism in Different Countries, of the International Congress on Alcohol and Alcoholism, Stockholm, Sweden, July 31st to August 5th.

Award 12 Scholarships

As it has done in past years the Alcoholism Research Foundation has sponsored grants to enable 12 selected professional people from various parts of the province to attend the annual Yale Summer School of Alcohol Studies during July of this year. The following attended: from Hamilton: Dr. J. K. Braham, psychiatrist; Dr. H. L. Thoman, a physician; and Miss Alice Barbara Steven, a nurse; from Toronto: Dr. Mary J. Eddis, psychiatrist; Mrs. Hazel L. Hogue, nurse; Mr. William D. Miller, social worker; Miss Jeannette E. Watson, university nursing professor; Mr. Alan Marcus, psychologist; from other parts of the province: Mr. Stanley Main, Woodstock probation supervisor; Mr. William A. McClure, Ottawa social worker; Mr. Ian Sutherland, Sault Ste. Marie Children's Aid Society director; and Flt. Lt. Jack Young, R.C.A.F. social welfare officer.

Appointments and Awards

Magistrate C. O. Bick, Chairman, Toronto Metropolitan Board of Commissioners of Police, has been appointed (by order-in-council) a Member of the Alcoholism Research Foundation.

William A. Woodruff, M.D., formerly with the Ontario Hospital, Hamilton, now director of Ontario Mental Health Clinic, Ottawa, has been appointed Chairman of the Medical Advisory Board of the Foundation's Ottawa Branch, and as such has also been appointed (by order-in-council) a Member of the central Medical Advisory Board of the Alcoholism Research Foundation.

P. J. Giffen, M.A., Assistant Professor, Department of Political Economy, (Sociology) University of Toronto has been appointed director of the Special Research Project on Chronic Drunkenness Offenders which is being launched by the Alcoholism Research Foundation under a special grant from the Government of Ontario.
This project has been planned by the Foundation in response to inquiries by the Department of the Attorney General which is concerned with finding out more about chronic drunkenness offenders so that improvements may ultimately be made in methods of dealing with the thousands of offenders who come annually before various magistrates' courts in the province.

Dan Hill, former executive secretary, area planning council, of the Social Planning Council of Metropolitan Toronto, has been appointed Assistant Director of the Special Research Project on Chronic Drunkenness Offenders.

David Wm. Grieveson, formerly caseworker with the Toronto Neighbourhood Workers Association, has been appointed to the Toronto Clinic staff of the Alcoholism Research Foundation as a psychiatric social worker.

Reginald Smart, M.A., Senior Research Assistant, has been awarded a University of Toronto Open Fellowship for the 1960-61 session of the School of Graduate Studies.

Back Issues Wanted

The A.R.F. Library is in the market for back issues of The British Journal of Addiction (formerly the British Journal of Inebriety), especially for the period 1941-1949.

Persons wishing to donate or otherwise dispose of such publications to somewhere that they will always be available to students of the subject should send a list of what issues they have to the Librarian, Alcoholism Research Foundation, 24 Harbord St., Toronto 5, Ont.

Foundation Moves

When former A.R.F. office and Toronto clinic buildings (see 1 & 2 below) were demolished for subway construction, these facilities were relocated in converted buildings at Harbord St. The Research and Education Departments (3 & 4) are remaining for the time being at 35 and 17 Prince Arthur Ave.

Clergyman Discusses Rehabilitation Of Problem Drinker and His Family

By Rev. H. D. Joyce, B.A., B.D.*

No one who has had the challenge and sometimes doubtful privilege of counseling a problem drinker, would begin to write brashly under such a heading. Memories of many failures will prick any fanciful claims to expertness. And even the dramatic success which has sometimes followed your efforts, leaves you wondering just what it was, or how, or who, that really contributed to the transformation. But whatever change may come from an honest and humble attempt to help a problem drinker, it is almost certain that the counsellor will himself be changed, and usually for the better.

For the purpose of these paragraphs, let us use the word "alcoholic" rather than problem drinker — partly because it is a simpler word, and partly to accustom ourselves to the term . . . in its proper meaning. By "alcoholic" we do not mean a skid-row derelict or drunken bum — although he may be so classified by prejudiced people.

A problem drinker is one who has a problem with alcohol, naturally; but we incline too easily to believe that if only he would cut out his stupid drinking practices he would automatically become a decent citizen and father. This is to misunderstand the whole nature of the case, and with a wrong diagnosis it is almost impossible to discover a cure.

The term "alcoholic", on the other hand, describes a person who is suffering from a complex disease of the whole personality, and having discovered the deceptive relief of narcotic alcohol, uses it with such compulsion that he is not able to control the time, place or amount of his drinking.

This doesn't mean that he is constantly drunk; nor is he necessarily a wife-beater and child-neglecter, or any of the other caricatures which have been so frequently drawn. He is a man

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* Mr. Joyce, now minister of St. James' United Church, Ottawa, was formerly minister of Dundas Centre United Church, London, Ontario, and prior to that in Saskatoon. In all these charges he has worked closely with members of Alcoholics Anonymous; and in 1957 in London contributed to 13 weekly half-hour television programs on the 12 Steps of A.A. which formed part of the public service series that won the annual Beaver Award for station CFPL-TV.

with a problem — often so deeply rooted and concealed that he doesn't know its real source or nature — but a problem which he cannot see over, or under, or around. And in beverage alcohol he has found a crutch for his weakness, a mute to soften the "fiend voices that rage", a narcotic to deaden the pain of being what he is. (If this sounds like a preacher's purple passage, I can only offer that each of the above is a quote from men whom I have known intimately.)

Making Effective Contact

The first approach to a clergyman may well come from the man's family or friends. This is hard, because one of the hardest rules for a distracted family to accept is the fact that it is almost impossible to help a man until he himself wants to be helped. Frequently, in the loneliness of his inner pain, a good man will turn so violently against his family, friends and minister, that any attempt to reach him will only drive him that much farther away, and delay by so much longer the possibility of a cure.

The well-meaning wife who will ask, "I wish you would go and talk to him, but don't let him know I told you or he'll be furious", is actually complicating the whole problem. Hard and dreadful though it may be, the surest and shortest way to recovery is usually to "let him go", until of his own tormented self he asks for help. Alcoholics Anonymous used to stipulate "an honest desire to stop drinking". But experience has led them to delete the word "honest", and to move with understanding speed to help anyone who shows even the slightest desire to desire sobriety. If a preacher wants some sanctified justification for this, he might find it in the lines penned by some anonymous sinner who had discovered the abounding grace:

"Who so draws nigh to God one step
through doubtings dim,
God will advance a mile
in blazing light to him."

Some Basic Assumptions

Assuming that a problem drinker has opened such a door to you, how do you go in? First, some basic assumptions (and I am sorry if these go contrary to established temperance thought): Remember that alcoholism is a *symptom* of sickness, and not necessarily the sickness itself.

There are people who overindulge on occasion, or even quite regularly, simply because "they like the stuff". Such people are hard to reach, and are not really what we mean by "problem drinkers" except to the doctor who has to try to counteract the effects of their liquor on their liver.

His Solution to His Problems

The real alcoholic, on the other hand, may hate everything about booze and describe it in the most loathesome terms, yet drink himself into bestiality with terrible regularity. He has a problem, and alcohol seems his only answer. It may be rooted in his family life, his job, his business concerns; it may be the result of personality defects, deep buried in his past; it may be an overpowering sense of inadequacy, in physique, in brain-power, in spiritual understanding. It may be a complex of emotions, so involved and ingrown that only an expert can root them out. But whatever and however, you can assume that he has a problem, and his drinking is the symptom.

Is he a sinner? Yes, in the sense that he may have broken many — or all — of the moral commandments, and suffers excruciating pains of remorse and fear. Remorse over the things which he remembers all too clearly and for which he can find no forgiveness; fear over the dreadful knowledge that during periods of drunkenness or alcoholic amnesia he may have done God knows what. And fear can assume such distorted proportions that it becomes a haze through which everything else is only dimly seen.

Is he a sinner? Yes, in the sense that he is separated from the purpose and grace and love of God. I have always thought it significant that when I asked a group of alcoholics what they wanted me to talk about, their one request was couched like this, "How can a good God have anything to do with a ———— like me?"

What He Already Knows

But if you approach him on the grounds that he is a sinner because he is drinking too much, or because he has beaten his wife or neglected his children, or has conducted an adulterous affair with his neighbour's wife — it is unlikely that you'll get far into his real problem. He knows, far better than you do, what he has done, in all its obscenity. And you won't easily find words, however harsh, that he hasn't used a thousand times

on himself. It isn't your place to call him a sinner — he *knows* that — but he can't find the way out!

Is he sick? Well, if you are asking whether alcoholism is a physical disease, like an allergy response to the chemical constituents of alcohol, I think you will find that science still doesn't know, but doesn't think so.

But he is a sick man.

Physically he may be ill from under-nourishment and over-indulgence in a harmful chemical which has had a medical effect on nerve tissues and vital organs.

Mentally he may be very ill, with problems magnified out of all true proportion and perspective, and with mental attitudes which make him emotionally incapable of logical thought.

Emotionally he may be ill through prolonged reaction to the attitudes of his family, friends, business associates, church people, etc., etc. Later on, he will recognize this as his "stinking thinking", but until he faces up to himself he will go on bitterly resenting it all, and hating the world in general.

And spiritually he is sick, being cut off from God and the fellowship of decency — partly ostracized by an outraged society, and partly by his own attitudes — again, his "stinking thinking". He may well be smarting under the constant rebukes of well-meaning people, and the tearful exasperation of his closest loved ones. He may have had more than one memorable run-in with good church people, and have been castigated roundly by a variety of clergy (to whom he may have gone with an inarticulate desire for help.) The possibility of a bright-faced and smiling acceptance of what *you* are going to say to him, may be somewhat remote.

Willing Understanding

How are you going to help him then? If there is any one word that gives the key to it, it is "understanding". That's what we have been trying to do above — understand his basic motive in drinking, his physical and mental condition, his fears, his estrangement from life, his attitudes toward those who want to help. Being *willing* to understand, listen to him! Let him talk. Listen to what he is trying to say. Usually it will be a hopeless garble of disjointed complaint and tearful confession. But listen, as he tries to purge his system of pent-up bitterness, resentment, remorse,

"Sickness" and the Professions

Programs whose goal is to improve the emotional conditions of disturbed individuals have been interpreted to the public with concepts tending to show that the emotionally disturbed individual is "just" as sick as the individual suffering from body illness. Goals such as "mental health" and "mental hygiene" are then grasped by the public as very similar to the goals understood by the terms of physical health and physical hygiene.

Of course the differences between the two sets of goals are outstanding. It is enough to point out that we have a clear idea about physiological normality but only blurred conceptions about psychological normality. It must be granted, however, that these implied similarities have appealed to the public and have fostered, at least temporarily, more tolerant attitudes toward the emotionally disturbed.

It is more acceptable to help the "sick" and therefore irresponsible, than the sinner and therefore guilty. This works until the public realizes that the distinction between the sick and the sinner is not clear-cut. This realization leads to renewed hostile attitudes toward those who can be helped only through understanding and tolerance.

All these trends and factors have fostered a conception of psychotherapy as a technique, and thus favored its separation from other disciplines which deal with man, his destiny and his goals (philosophy, religion, theology, history). That this separation is a source of some concern is proved by growing attempts at cooperation between religious and professional groups in order to achieve a better approach to emotionally disturbed individuals.

—*Georgio Lolli*
in his article: *"Therapeutic" Success In Alcoholism*

Quart. J. Stud. Alc. 14:2, June, 1953

frustration, fear, feelings of inadequacy, and the rest. And whatever he may say, you are not wasting time. The apparent beating-around-the-bush may be his urgent and skilful testing of your reactions to many subtly-introduced areas of his life — all of it bent to discover whether you are the kind of man with whom he can share the deepest confidences of his soul.

Some things should go without saying in your approach to him: if you resent his resentments, and answer his bitterness with a similarly bitter defence of your outraged ego, you had best leave this kind of counseling to others who are

more secure in their calling. And you must never relay information which he has given to you; not even under the strongest urging of family or friends. Your betrayal of his confidence will almost certainly be found out sometime, and all you have built together will come tumbling down. Only if you have his explicit permission are you free to discuss his problem with anyone. And of course, all this will take more than one "interview".

Even the most skilled minister is a fool, and a conceited one at that, if he thinks he can lay bare, discover and correct problems which have accumulated through many years, and then somehow fortify an infant will so that it will be strong enough to face problems which are really staggering.

Friendship vs. Advice vs. Sympathy

Offer him friendship, but be careful about advice. Especially pious advice. Even if you are right, it is unlikely that he will be capable of receiving your counsel or acting on it effectively. It is a simple matter of physics that you can't cram ideas, even good ones, into a mind that is crammed full already. He has to get rid of so much before he can accept even a little.

Be careful with your sympathy. He will take great gobs of it if you will offer it, but it won't do him any good, and it can do much harm. Your well-meant words can fortify his feelings of inadequacy, and confirm his belief that in the eyes of God and men he is a hopeless case.

And be very careful about offering financial help in any form. What the average alcoholic needs first is to recover his lost sense of manhood, his independence, his self-respect, his confidence that he is able to meet and overcome his problems, by the grace of God, the intelligent understanding of his friends, and the inner resources of his own re-awakened and encouraged will. Undoubtedly his first weeks or days on the road to recovery will be pretty shaky, and his provision for his family may be far short of what you or they would desire; but he *needs* to do it, by himself, and the very fact of their dependence upon him, and the sheer marvel of their survival through those days, will nerve him to keep on. To give him assistance, even when he pleads for it, may well be to take from him his sense of independence, and can prolong his ultimate recovery.

(At the same time, it is possible to arrange for assistance in such a way that he has responsibility for full repayment on a definite plan. This gets him over a rough spot without cutting at his self-respect.)

Traps to Avoid

Don't be misled into a feeling of victory just because he has stopped drinking. Some of the most stubborn alcoholics can go for months without touching a drop. But unless the root cause of his problem is discovered and dealt with, you haven't really accomplished much more than a delaying action. And of all pitiful people, the "dry drunk" is surely one of the most desperate. Lost, still out of balance with the world, himself, and God, and miserable beyond reckoning. We're looking for more than sobriety; we are looking for contented sobriety — wholeness of body, mind and soul.

And finally, resist the subtle temptation to "play God" — to pull little strings of piety which you think will accomplish redemption and place another mark of victory beside your name. It is no accident that those who do "come back" always give credit to "the grace of God" by Whom they are what they are. He alone has created, and He alone can re-create. Our whole function is to help a needy spirit to open again the lines of communication between itself and God — to bring a sick personality to the Divine Physician — a lonely man to the Lover of souls — a weak will to Him who is both Strength and Salvation.

I have not mentioned the various agencies in the community which stand ready to help with this type of problem. Partly, I am assuming that everyone knows of the work of Alcoholics Anonymous, and will realize that they are among the very first to whom an alcoholic should be guided for help. Practically everything I have said has been based on intimate knowledge of their methods and experience.

The Alcoholism Research Foundation in Ontario is also an excellent referral society, and has skilled workers and resources which ought to be known to every pastor.

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alcoholism

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This periodical is published four times a year in the interests of a deeper understanding of the widespread disorder alcoholism.

Each issue contains pertinent, factual information selected primarily because of its interest to those who are called upon to deal with alcoholism professionally. Articles published do not necessarily represent the views of the Foundation.

If you would like to receive this publication regularly, or if you wish additional information about some aspect of alcoholism, you are invited to write to the Alcoholism Research Foundation, Education Department, 17 Prince Arthur Ave., Toronto 5, Ontario (WA. 5-8951)

There are also branch offices at:
155 James St. South, Hamilton (JA. 7-4941)
481 Queens Ave., London (GE. 9-1151)
1206 Bank St., Ottawa (RE. 3-8343)

Edited by Vernon H. K. Lang

Circulation of this issue: 10,

Vol. 7, No. 3
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alcoholism

RESEARCH
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Dean of Alcoholism Researchers Re-analyses "Disease Concept"

THE North American Association of Alcoholism Programs, at its recent annual meeting in Banff honoured one of the pioneers in this field, Dr. E. M. Jellinek, former Consultant on Alcoholism to the World Health Organization. A presentation was made to him "in appreciation for a quarter century of perceptive leadership, inspired research and sage counsel".

Within a few days of that event, Dr. Jellinek, through his publishers (Hillhouse Press, Box 1360, New Haven 5, Conn., U.S.A.), issued a new book, *The Disease Concept of Alcoholism.* In the course of analysing and comparing the whole gamut of theories on this matter, this new work presents a very much clarified picture of what is at present known about alcoholism. Such a publication clearly shows that the age of 70 may well be just the beginning of Dr. Jellinek's most significant period of contribution to science.

The Disease Concept of Alcoholism moves its readers in two directions at once. First, it broadens the "genus" alcoholism

to include (for purpose of discussion within the book) "any use of alcoholic beverages that causes any damage to the individual or society or both". Secondly, it divides the "genus" into "species" (at least five) and narrows down the disease or illness concept of alcoholism to include, with certainty, only two such "species", which Dr. Jellinek labels *gamma* and *delta:*

> **"Gamma alcoholism** means that species of alcoholism in which (1) acquired increased tissue tolerance to alcohol, (2) adaptive cell metabolism, (3) withdrawal symptoms and "craving" i.e. physical dependence and (4) loss of control are involved. In gamma alcoholism there is a definite progression from psychological to physical dependence and marked behaviour changes."
>
> **"Delta alcoholism** shows the first three characteristics of gamma alcoholism as well as a less marked form of the fourth characteristic—that is, instead of loss of control there is inability to abstain. In contrast to gamma alcoholism, there is no ability to "go on the water wagon" for even a day or two without the manifestation of withdrawal symptoms; the ability to control the amount of intake on any given occasion, however, remains intact."

It is made clear that "gamma alcoholics" predominate in North America, but not to the exclusion of other types which Dr. Jellinek's book describes under various Greek-letter labels; while "delta alcoholics" predominate in wine-growing cultures such as France—but again, not to the exclusion of other types.

The book goes on to consider what is known about such factors as tolerance, habituation, ethical involvements, symbolic implications of drinking, the "utility" of drinking and the pharmacological process of addiction. This part concludes with expression of the view that (a) the process of acquired increased tissue tolerance, and (b) the mechanisms of the various withdrawal symptoms, represent some of the more profitable targets for scientific research.

The final chapter is devoted to considering implications of public, professional and special group attitudes toward alcoholism, as they appear in various parts of the world.

Just a very few of the highlights of *The Disease Concept of Alcoholism* have been mentioned here. Anyone seriously interested in understanding alcoholism can and should profit by leisurely study of the book itself.

Memo to Top Management Re Problem Drinking in our Company

Following are the original texts of two internal memoranda about problem drinking in industry which were actually sent to the president and management committee members of a large Ontario industry employing some 5,000 persons. They went over the joint signatures of the chief medical officer and personnel department executives.

Memo No. 1 was a preliminary introduction which endeavoured to set the subject in reasonable perspective. **Memo No. 2,** which followed within a few days, deals specifically with problem drinking.

These are published as models which may be adaptable to use in other companies which are not yet taking constructive steps to meet this prevalent and very costly problem.

MEMO NO. 1

From the medical and personnel officers of company 'X')

During the last two or three years, a variety of illnesses of psychogenic origin have come to our attention. These have ranged from advanced psychosis to mild and sporadic anxiety states, and include problems related to the use of alcohol and also to problems associated with the process of aging.

During recent months the number of illnesses of this type that have come to our attention has increased. Whether this is merely a coincidence or can be related to recent changes in the conditions that exist here is, of course, impossible to say. In any case, there are ample reasons for our company to be concerned about the effects of these types of illnesses and to try to develop more systematic methods of bringing them to light and making proper treatment available. With this in mind, we have been discussing various ways in which our approach might be made more effective.

Although functional disabilities are extremely varied, each type needing a unique approach, we have decided that one obvious area where something can be done is that of alcoholism and problem drinking. From existing studies, we can estimate with reasonable accuracy the probable extent of this type of illness

here. The social and psychological costs to the individual and economic costs to the company are hard to assess accurately but there is no doubt that they are high. Because of attitudes surrounding the use of alcohol, personal difficulties associated with it do not come easily to our attention.

In the past, we have approached each case on its merits as it became known to us through existing channels. We now feel the extent of the problem is such as to warrant a more systematic approach. We have reports outlining the experience of other companies in dealing with this problem. These report would lead us to expect a fair measure of success if we developed such a systematic program here.

We have no intention of jumping off with appropriate fanfare into a large-scale project. Quite the reverse is true. We would like it to become known in as quiet a way as possible that proper treatment is available. Eventually, we would hope to bring about a climate that would enable employees not to feel threatened when considering whether or not they should seek out this treatment.

All we would request now from top management is that they accept our concern as being realistic and lend support in any way they think possible in the development of a climate among our employees that will encourage them to seek out treatment, knowing that in doing so they will receive the support of their individual supervisors and management generally.

MEMO NO. 2

(Sent by the medical and personnel officers to those management office who had received Memo No. 1 a few days before.)

Perhaps the following observations may prove useful i your consideration of the question of problem drinkin as it affects our company.

What is problem drinking?

In an industrial context, this condition is said to be present when repeated indulgence in alcoholic beverage has reached the point where intoxication or its after-effects are manifestly interfering with the efficient performance of an employee's assigned duties. At this point the employee's drinking, which he or she may previously have contended to be entirely a personal

matter, becomes the legitimate concern of the employer and he therefore has a right to intervene.

How prevalent is problem drinking?

Such surveys as have been made in North American industrial communities (including a well documented study by the Alcoholism Research Foundation of Ontario) indicate a prevalence ranging from 3 to 6 per cent of the total payroll. In 10 years of operating a treatment program in this field, Consolidated Edison of New York reports the recognition of about 400 cases, averaging some 40 new cases per year in a group of 25,000 employees.

Certainly many more cases exist than are readily recognized; and it would be a safe assumption that our company with 5,000 employees, unless it is unique in this respect, has a minimum of 150 problem drinkers on its payroll — even though the majority of these are at present hidden.

Why "problem drinkers"?

Over the past 10 years, the experience of a number of major industrial companies in the U.S. and Canada has indicated that the term "problem drinker" is much more acceptable and more readily understandable than the term "alcoholic". "Alcoholic" still conjures up the stereotype of the Skid Row bum, whereas "problem drinker" usually evokes a picture of a man who is slipping but who still has a job, a home, and a family — along with his mounting problem.

How can problem drinkers be recognized?

An individual's pattern of absenteeism offers a major clue. Repeated Monday morning, post-holiday, and post-payday absenteeism has been shown to reveal likely problem drinker suspects which may be confirmed by subsequent investigation. Flimsy excuses, alleged "sore back", etc. are offered. Days absent per year for the alcoholic group have been found to be about double the average for the non-alcoholic group. On-duty accidents are not excessive among problem drinkers, but they often have more than their share of off-duty accidents, particularly with assault as a factor. Personality changes gradually become apparent in the developing problem

drinker, operating errors and incompleted work assignments become more frequent. Financial problems usually beset the problem drinker and his family.

Who can spot the problem drinker?

Key man in the industrial setting is the problem drinker's foreman or supervisor. He will be the first to become aware of frequent whole or part-day absences, evidences of hangover, slipping efficiency, increasing mistakes and rejects, personality changes that make the man harder to get along with.

What can be done when a problem drinker is recognized?

Worst and most frequent error is to ignore the early signs that a man's drinking is causing him serious trouble. Best and most difficult step is to confront the man with the evidence that his work is slipping seriously and to gain an admission from him that this is because of his drinking.

Every case is different, just as every man and woman is unique, and so there is no pat formula for attempting to counsel a problem drinker. Before a foreman or supervisor voices his suspicions to anyone else, he would be well advised to discuss them with the appropriate person in the company's medical or personnel department. It is possible that his observations will dovetail with those from other sources and indicate a course of action.

Certainly it is a grave mistake for a foreman or supervisor to cover up for a man in the hope that he will pull himself together. It is worse than useless just to tell him to pull his socks up and he'll be given another chance. If there is one generalization that can be made about the alcoholic it is that he is a past master at the art of taking advantage of any sign of softhearted kindness that is not solidly backed up by a measure of discipline. He is also notable for his ability to rationalize any act or attitude he finds necessary to the continuance of his drinking.

Company policies on problem drinking

Among the larger Canadian companies, Bell Telephone and Imperial Oil are two which have gone far in dealing with problem drinking as a medical matter.

In 1951 Bell Telephone officially recognized alcoholism or problem drinking as a pensionable illness and provided sickness disability benefits and medical help. Since that time more than 300 cases have been referred to their medical department for help and worthwhile results have been achieved "in over half of these".

Imperial Oil has proceeded less formally and more quietly and has not yet reported on the statistics it has been gathering for several years.

In the United States, in addition to Consolidated Edison, notable plans are in operation at Allis-Chalmers, E.I. duPont de Nemours, Eastman Kodak, the Norton Company, and Standard Oil of New Jersey. Reports are available on these.

Generally, it is felt by those experienced in handling this problem that an element of coercion is effective in motivating most problem drinkers toward treatment. The employer, by definition, is in a position to supply a motivating force through his prerogative of continuing or terminating an employee's job. The use of this implied coercion is a delicate matter requiring skill in human relations.

An indicated course of action here

A broadside propaganda campaign aimed at problem drinking is definitely not indicated, and indeed would probably defeat itself. Much more effective would be a quiet effort to increase the awareness first of job placement officers and others in our personnel department, and later plant and office supervisory personnel, with respect to this condition and to the fact that problem drinkers can be helped.

Help, following recognition and referral of cases to the medical department might involve one or several possible resources as indicated — in-plant counselling and individual medical treatment, formation of a small group for superficial psychotherapy and enlightenment about alcoholism and its sequelae, referral to Alcoholics Anonymous or referral to the Alcoholism Research Foundation Clinic on an out-patient basis.

A critical element in the effectiveness of any such procedures would be the firm attitude of the company in the matter of insisting that a problem drinker cooperate in the prescribed treatment program — on pain of dismissal. (Consolidated Edison actually places the employee on formal probation for this period of treatment.)

The most effective way of bringing a treatment and rehabilitation program into operation is by the successful treatment of a few cases in various parts of the company. News of such successes is bound to travel and as it does it will bring hope to problem drinkers themselves and to their foreman and supervisors. Gradually there will be less hiding of the problem and greater willingness on the part of staff at all levels to discuss and refer cases, and even to come forward voluntarily for help.

No panacea, but worthwhile progress

Certainly no industrial health plan is successful in completely eradicating such a condition as problem drinking; nevertheless companies which have had several years' experience with plans to relieve problem drinking are satisfied that the effort is worthwhile.

Dr. Harvey Cruickshank, vice-president and general manager for the Toronto area of Bell Telephone, says; "On the purely practical level our company is satisfied that the program is justified through the reduction in absenteeism and in necessary separations."

Dr. Charles Franco, medical director for Consolidated Edison, reports that of 398 cases coming to their attention between 1948 and 1957, 209 had been able to maintain their jobs as a result of treatment they were obliged to take. Furthermore, a breakdown into three periods (1948-51, 1952-55, and 1956-57) shows a steadily improving success record (40% in the early years, 55% later, and 71% in the latest 70 cases). This improvement is ascribed by Dr. Franco to experience and to the ever earlier detection of cases — no advanced alcoholics with organic deterioration were discovered in the last two-year period. Earlier recognition enhances the chances for successful rehabilitation.

A recommendation

On the basis of experience, therefore, it can be concluded that a company the size of ours must have at least 150 problem drinkers on its payroll and that these men and women are slowly but steadily deteriorating eventually to the point of total disability. In the meantime their efficiency is decreasing and they are becoming more of a burden to their supervisors and to those working with them.

This is a situation which can, in 50 to 60 per cent of cases be arrested and remedied — these are people who can be rehabilitated and restored to their former, more effective roles on the job and at home with their families. We would submit that to thus aid more than 75 of our personnel at various levels is a task well worth tackling with the resources we already have within our reach.

SOMETHING FOR THE CUSTOMERS

"Deciding what to give used to be a major problem here," says a branch sales manager in Chicago, "until we finally gave up fighting it year after year.

"Now we give everyone liquor—a case to our big customers, half-a-case to lesser accounts and a bottle or two for now-and-then customers. Since our gift list remains relatively constant, we know every man's tastes by now."

Other companies have stopped giving liquor. Explains one assistant to a sales vice president: "We felt it was consumed and forgotten. I think we even got blamed subconsciously for hangovers."

A firm which gave liquor to everyone two years ago last year switched to pheasants and turkeys. "Everyone gives liquor," says the sales manager. "We simply felt it was losing its significance and value as a gift."

—Quoted from *Salesweek*
September 5, 1960

Reducing Use and Supply of Spirits Is Target of Swiss Authorities

FOR the better part of the century various countries have included in their efforts to deal with alcohol problems some sort of policy designed to encourage a shift in alcohol consumption away from distilled spirits and towards milder beverages such as beer and wine.

Most such policies (in Britain, Belgium, Sweden, and to some extent North America) have simply aimed at making distilled spirits more expensive to the consumer than weaker types of beverages. Switzerland has made similar attempts to influence demand through price, but it has also developed other policies aimed at reducing not the demand but the actual supply of distilled spirits. The Swiss authorities apparently regarded their problem of excessive alcohol consumption as being intimately related with assorted problems of agricultural overproduction within the Swiss economy.

Prior to establishment of the Swiss Confederation in 1848, the various Swiss cantons had dealt with the trade in alcohol mainly through taxation by the individual cantons.

The first move in this field by the new federal authority was in 1885, with a law setting up a federal alcohol monopoly and forbidding farmers to distill potatoes. The legislation at that time also authorized the cantons to limit the number of drink-selling establishments and inns.

There was one large loophole in this legislation: the distillation of fruits and wine was not under the control of the monopoly and was, in fact, tax-free. In effect, therefore, potato spirits were eliminated, grain spirits were taxed, but fruit spirits continued to grow in volume.

The alcohol monopoly itself was charged with facilitating the ultilization of potatoes by taking over certain quantities of alcohol produced from potatoes. After 1921 the alcohol administration began to avoid any further distillation of potatoes by simply subsidizing the sale of surplus potatoes on the open market.

During the 1920's the marketing of surplus fruit began to be a problem, and this in turn was reflected in a considerable increase in distillation of fermented fruit juice. As a result, the

federal law on alcohol was overhauled in 1930 and the new law became effective in 1932. The following summary of this legislation and its operation has been supplied by the Swiss Federal Alcohol Administration.

The Swiss Federal Law on Alcohol of 1932

1. Objectives

   a) to protect public health by the reduction of the consumption of spirits,

      —by raising the price of distilled beverages through taxation;

      —by reducing the number of distilling apparatuses through purchase by the Federal Alcohol Administration;

      —by limiting distillation and by encouraging the non-alcoholic utilization of fruit and potatoes.

   b) to benefit the country's economy

      —by utilizing the surplus of the fruit and potato crops for fodder and food and by developing arboriculture with a view to obtaining fruit of a quality satisfying the demands of the market;

      —by providing the country with alcohol for pharmaceutical and technical purposes.

   c) to obtain a revenue which must be employed for social purposes. One half of the net receipts of the Alcohol Administration* coming from the taxation of spirits and alcohol after deducting expenses incurred in the utilization without distillation of fruit and potatoes and administration expenses, is paid to the Federal Old-age Insurance Fund.
   The cantons receive the other half but are obliged to employ at least 10% of their share for the combating of alcoholism by subsidizing private societies and institutions (the "alcohol-tenth").

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*The Swiss Federal Alcohol Administration is the body responsible for the administration of the alcohol monopoly in Switzerland. It is not, however, simply concerned with fiscal and administrative problems relating to the production and utilization of alcohol but is actively concerned in reducing alcohol consumption and encouraging the non-alcoholic use of fruit and potatoes by the population in the interest of public health.

2. Operation

a) The alcohol administration system comprises a monopoly conferring on the Confederation the right of subjecting the distilleries to licence, of taking in its charge the distilled product, of importing spirits and alcohol and of putting alcohol on sale at a price which includes a tax, of fixing the tax to be paid on spirits which can be sold without passing through the monopoly administration and of exercising a control of all production operations and of all trades in distilled spirits and alcohol. This task, like that of the encouragement of the non-alcoholic utilization of fruit and potatoes, is entrusted to the Federal Alcohol Administration having an independent legal status but placed under the authority of the Federal Department of Finances and under the supervision of parliamentary committees set up for that purpose.

b) The law envisages licences granted to:

i. **professional distilleries,** which consist of:

—the sugar factory at Aarberg which distils molasses, and

—the cellulose factory at Attisholz which distils residuary lyes

—1250 distilleries of an agricultural type, namely distilleries of pip-fruits (apples and pears) or specialties (cherries, plums, prunes, "grape marcs") working on their own account and distilleries working for farmers not having stills of their own.

ii. **domestic distilleries,** operated by farmers who enjoy tax exemption in respect of the needs of their farm and household. Although the Administration has greatly decreased their number by the purchase of stills, they still number about 23,000. To these must be added the farmers mentioned above who, because they do not possess a still, can get distilling done with tax exemption. There are now, therefore, about 157,000 agricultural producers who benefit from

tax exemption for spirits. This exemption had to be granted at the time when the new legislation was voted by citizens and cantons in 1930.

c) The rates of tax fixed for the production and sale of spirits are as follows:

—for spirits produced from specialties (cherries, plums, etc.) 5 francs per litre at 100%

—for spirits produced from pip-fruits

—produced by professional distillers 5 francs 70 per litre at 100%

—sold by domestic distillers 5 francs 20 per litre at 100%

As regards the imported spirits a monopoly duty is levied in addition to the customs duties on spirits as well as on the raw materials imported.

d) **Restriction of distillation.** The distillation of apples and pears by professional distilleries, which not so long before had been excessive, was restricted according as other ways of utilization excluding distillation were practicable. This means that during years when the crop was medium or small there was no distillation of pip-fruit at all. Distillation only took place when the crop was large.

e) **Encouragement of alternative uses.** Non-alcoholic utilization has been aided by:

—development of the production of non-fermented fruit-juices;

—transformation of fruit surpluses into concentrated juices;

—production of vinegar from fruit;

—drying of fruit "marcs" for fodder and the production of pectin;

—measures encouraging the drying of fruit, and

—measures to promote the sale of table-fruit.

Looked at in relation to half a century or so, there is little doubt that spirits consumption declined drastically in Switzerland. However it has done so in many other countries too.

Looked at in terms of the period since World War II,

the result is less certain. Considering all forms of alcoholic beverage together there has been some slight postwar increase in Swiss per capita (adult) alcohol consumption. It has been suggested that policies which for a time reduce alcohol consumption by high beverage prices may lose their effectiveness when incomes and prices catch up with beverage prices through inflation of the general price level.

Alcoholic's Wife Presents Her View Of How Wives Do or Don't Help

The following graphic description of some of the inconsistencies in measures taken by alcoholics' spouses is part of a larger article submitted by a woman who has first hand experience of what she is talking about. At her request we are withholding her name to protect the traditional anonymity that is accorded to all first-person statements by alcoholics and those connected with them.

THE early stage alcoholic is usually an employed person with a home and family. At this stage of his illness he still exercises control over his behaviour but, as the illness progresses, his controls become increasingly less effective. More often than not he is above average intelligence and is able to function reasonably well in a community for years without being recognized as a sick person by the casual observer. The picture at home will be a different one.

A drinking problem in the home will often be more easily recognized by the wife's behaviour than by that of the drinker. For example, she will probably:

make excuses for her husband's drinking behaviour;
mother him;
keep up appearances for the rest of the world;
see that he gets his hair cut and is properly dressed;
be sure he is wakened in time to get to work;
be sure to phone his place of employment and tell his employer he is ill if he is unable to make it;
cover up for him to the neighbours;

make every effort to get food into him;
stay away from people almost entirely or go out as often as possible to get away from it all;

do much of the work around the home which is usually associated with men;
work to increase the family income or else supply all of it;
obtain employment for her husband through her connections or help him with his work;
clean up the bed when he vomits or worse;
complain about it, then do it again;
tell him not to strike or yell at the children;
strike or yell at the children herself;
pay his bills for him;
buy or supply the furniture for him;
(mothers do a good bit of these latter two);
control the finances (as much as she can lay her hands on);

arrange for the entertainment, if any;
drink with him so he will not become so intoxicated;
encourage him to drink at home so she can keep an eye on him and the rest of the world will not know about it;
tell him to get out so she will not have to look at him;
send the children to bring him home;
phone around to locate him;
tell him he doesn't love her anymore (he will make a similar complaint);

complain about the money he spends on alcohol;
buy more for him or give him money for it;
pour it down the sink;
blame his drinking on his job;
blame it on his friends or the crowd he works with;
blame it on the army, navy, or air-force;

console him when he feels sorry for himself;
tell him not to feel so sorry for himself;
use sex as a weapon to control him;
lie about the amount of money they owe or have on hand;

run up bills so he will not have enough left to drink on;
worry over him;
cry over him;
scold him;
beat him;
refuse to sleep with him;
sleep with him;
try to reason with him;
keep on having children by him;
buy him all kinds of tools or sports equipment so he will have something to do besides drink (waste of money—he will drink anyway when the novelty wears off);
leave him;
come back to him;

spend the night in a hotel;
spend it with the neighbours;
spend it with him;
threaten to leave for good;
fail to carry out the threat;
run home to mother;
scream at him;
swear at him;
give him the "silent treatment";
run to his mother;

tell him to phone if he will not be home, then argue or scold when he does;
encourage him to try controlled drinking so she will not have to go without hers;
wait on him;
tell him to wait on himself;
arrange to tie up most of his free time so he will not have time to drink;

charge him with assault;
withdraw the charge;
keep herself and the home spotless;
let herself and the house fall apart;

refuse to take another beating;

encourage him not to drive when he drinks so he won't get himself in a jam;

get him out of the jam;

cheat on him because he cheated on her;

hate him;

hate his mother;

try to get help for him;

cook for him;

tell him to cook for himself because he failed to come home to eat what she prepared;

pray he will quit drinking;

pray he will drink himself to death;

hope he will break his neck before she does it for him;

and, finally—usually when some crisis in the home forces her to do so—she will do the one beneficial thing a wife is able to do, get her husband out or get herself and the children out of the home unless he quits drinking for life and accepts treatment.

I do not say a wife is right or wrong in what she does—no one can live in peace with an active alcoholic—but I do say this is how a wife will react to a drinking problem in the home.

Are you able to see how completely useless it all is and how completely ridiculous a wife makes herself look—even to herself?

Are you able to see that a wife, *by her own actions* (accepting responsibility for him, covering up for him, mothering him, maintaining a home for him, etc.), is only helping her man to drink?

Are you able to see that she is only helping to prolong the drinking years and the agony that goes with them?

The average alcoholic (said to be 45 years of age) would not be able to function as long as he does, if his wife (or mother) would allow him to stand on his own two feet where he properly belongs and accept the responsibility for his own actions. This harmful behaviour on the part of a wife (or mother) is not intentional; she is either unable or unwilling to see the damage she is doing.

A.R.F. Activity News

FALL 1960

The special study on chronic drunkeness offenders being done by the Alcoholism Research Foundation for the Attorney-General is now in full swing. Beginning November 1st a continuing sample of up to 10 offenders per week is being intensively interviewed and examined.

In addition, the program includes: (a) continuous gathering of data in Toronto's drunk court, (b) a special study of women offenders, and (c) a study (by 4th year sociology students) of Toronto's skid row area.

The department of university extension, University of Toronto, has this fall, with assistance from the Alcoholism Research Foundation and the University School of Social Work, been putting on a 10-evening course on alcoholism for social workers.

The Foundation's Executive Director, **H. David Archibald,** who for the past two years has been president of the **North American Association of Alcoholism Programs,** has now been succeeded (as NAAAP president) by Dr. John **R. Philp** of Berkeley, Calif. The change-over took place at the Association's annual meeting held recently in Banff.

John R. Seeley, former Research Director of the Ontario Alcoholism Research Foundation, has been appointed professor of sociology at Toronto's new second university, York University. He is continuing his association with the Foundation as a consultant.

Mr. Jan de Lint, an anthropologist has been appointed a senior research assistant in the research department and is presently working on projects related to alcohol consumption and advertising.

The Alcoholism Research Foundation has recently made three new research grants:

1) to **Professors Percy Ireland and Walter Johnson** of the University of Toronto Otolaryngology department for research into the effects of alcohol on vestibular function, i.e. the controls governing sense of balance. (Since it has been demonstrated that alcohol disturbs vestibular function, first when concentration is rising and then later during the hangover period, this new project may throw some light on the nature of the actual process of adaptation to alcohol, tolerance, etc.)

2) to **Professor D. W. Clarke** of the University of Toronto department of physiology, for research on phosphate metabolism in different parts of the brain. (The turnover of high energy phosphate is known to be directly related to nerve impulse transmission.)

3) to **Professor J. V. Basmajian** of the department of anatomy, Queen's University, for research on the effects of alcohol in peripheral nerves. (This may throw some light on whether some part of the neurological effects of alcohol works directly through peripheral nerves instead of or as well as through the brain.)

4) to **Queen's University,** to cover half the cost of a symposium on alcoholic cirrhosis being held there in November.

For the fifth year in a row the Foundation is providing for **clergymen** nominated by the Canadian Council of Churches a seminar course on alcoholism divided into six half-day sessions at weekly intervals.

The same technique has been adopted by the Foundation's **Hamilton branch,** which this month holds the third of its own separate series of the same type.

Miss Betty Kinch, the Foundation's nursing instructress went to Chatham, Mass. early in the fall on invitation to present a paper at a Massachusetts conference on alcoholism for nurses. Since then she has also participated in a one-day seminar **for industrial nurses** sponsored by the Foundation at the University of Toronto School of Nursing.

The Foundation records with great regret the passing of one of its most able and helpful Members, Mr. William Trimble, who helped to guide our policies from 1954 until his death earlier this fall.

Vol. 7, No. 4 Spring, 1961

alcoholism

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This periodical is published four times a year in the interests of a deeper understanding of the widespread disorder alcoholism.

Each issue contains pertinent, factual information selected primarily because of its interest to those who are called upon to deal with alcoholism professionally. Articles published do not necessarily represent the views of the Foundation.

If you would like to receive this publication regularly, or if you wish additional information about some aspect of alcoholism, you are invited to write to the Alcoholism Research Foundation, Education Department, 24 Harbord St., Toronto 5, Ontario (WA. 5-8951)

There are also branch offices at:
155 James St. South, Hamilton (JA. 7-4941)
481 Queens Ave., London (GE. 9-1151)
1206 Bank St., Ottawa (RE. 3-8343)

Edited by Vernon H. K. Lang

Circulation of this issue: 12,0

Vol. 7, No. 4
March, 1961

alcoholism

RESEARCH

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Digest of Tenth Annual Report of Alcoholism Research Foundation

(Page references are to the complete report, which is now available)

THE Alcoholism Research Foundation of Ontario, first official organization to study alcohol addiction in Canada, in its first 10 years has provided treatment for more than 7,500 alcoholics (of the estimated 85,000 alcoholics in Ontario), conducted 110 separate research projects, and developed an extensive public education and professional training program. *(Page 5)*

Several Kinds of Alcoholics

This experience has made it clear that alcohol addiction is not a single entity for which there might be a single uniform treatment. There are several different kinds of alcohol ad-

diction; and two main groups of alcoholics might be described as follows:

(1) those drinkers who, while they can easily control the amount of alcohol they will consume on any one occasion, are unable to tolerate complete absence of alcohol from their system;

(2) those drinkers who, while quite able to do without alcohol for indefinite lengths of time, are unable, once they begin drinking, to control the amount they will consume on that occasion.

In Canada and the United States this second kind (those unable to stop drinking once they start) is most commonly seen among clinic patients and in A.A. *(Page 9)*

Human Adaptation to Alcohol

Under the guidance of Dr. Harold Kalant, who became Assistant Research Director in charge of biological studies in 1959, the Foundation has begun a new series of grants for fundamental experimental work in physiology. The aim is to throw new light on the processes of human adaptation to alcohol. *(Pages 10 & 50)*

An interesting clinical study now under way involves the effects of tri-iodothyronine, a substance which is alleged by some to affect the rate at which alcohol is oxidized in the body. *(Pages 10 & 51)*

In the behavioural sciences one of the Foundation's most interesting current projects is an investigation by Dr. Muriel Vogel into the relation between certain personality factors, the alcoholic drinking pattern, and condition-ability in alcoholics. *(Pages 10 & 51)*

Price, Alcohol Consumption, and Addiction

In the social science field, an inquiry into the effects of beverage prices, begun by Mr. Harold Greer of The Toronto Globe and Mail, published in 1959, has been gone into more intensively by the Foundation's former Director of Research, Mr. John Seeley. Mr. Seeley compared relative alcohol prices (expressed as fractions of average adult annual disposable personal income) with adult per capita alcohol consumption and with adult standardized death rates from cirrhosis of the liver (the latter having been used for many years as the basis for official estimates of the prevalence of alcoholism).

The results of this study, as reported in the Canadian Medical Association Journal, provide almost overwhelming evidence that alcoholism and adult alcohol consumption rise and fall together. For Canada as a whole, 96 per cent of the variation in alcoholism rates could be considered attributable to changes in per capita consumption. And of the variation in consumption, 94 per cent can be accounted for by the variation in the relative price. The additional fact that both Canadian and Ontario data give almost identical results makes more plausible the view that there may be a true causal relationship between price and consumption.

One reasonable conclusion from this evidence is that the relative price seems more likely to affect alcohol consumption (and hence alcoholism) than other traditional instruments such as limiting the number of outlets, hours of sale, or restrictive permit systems. However, only an experiment with actual price changes over a large enough area can determine with certainty whether (as this study indicates to be probable) an adequate increase in the price of alcoholic beverages would reduce alcohol addiction. *(Pages 11 & 12)*

Chronic Drunkenness Offenders

Further differentiation among kinds of alcoholics is being developed in a special research project launched in 1960 to learn more about the chronic drunkenness offender. Directed by Professor P. J. Giffen and financed by a special provincial grant, a team of specialists is doing an intensive study of a sampling of individuals convicted repeatedly for drunkenness offences in Toronto's Court "G". This is for the purpose of learning enough about this group of offenders to serve as a guide for new legislation to facilitate the rehabilitation of such persons. *(Page 13)*

Limited Clinical Facilities

For both learning and teaching purposes the Foundation has been operating a variety of small treatment services in four Ontario cities (Toronto, London, Ottawa, and Hamilton). Apart from the newer Hamilton clinic, these treatment services had reached their patient capacity three or four years ago. During 1960 the Toronto clinic had to be moved from 9 Bedford Road to 24 Harbord Street to make way for subway construction, but this new temporary location is no

larger in terms of patient capacity than was the older Brookside Clinic. The Foundation is looking forward to establishment of somewhat more comprehensive clinical facilities in Toronto within the next two or three years, which will provide accommodation for an expanding clinical research and professional training program. *(Page 14)*

Wider Variety of Patients Admitted

The Foundation has been redefining its role as a clinical centre devoted to studying and helping to relieve all types of alcoholic problems. Toward this end the clinic has been reducing restrictions on admissions to treatment services, although still treating only those who come on a voluntary basis. Strict limits are no longer placed on the length of time a patient may stay in the Toronto clinic, and some acutely ill (intoxicated) alcoholics are now being treated on the premises. A number of patients with various degrees of cerebral deterioration have been admitted, and the staff is learning much about the future management of such cases. *(Page 23)*

Research and Teaching Demands on Treatment Staff

The Foundation clinics have seen their prime role as one of research and investigation into optimal or exemplary approaches to treatment, and do not contemplate being able to meet all the demands which may be put on them for service to the province's estimated 85,000 alcoholics. The hope is that any increase in staff and facilities will permit more complete investigation, more complete treatment and rehabilitation, and more complete recording and evaluation of the data gathered in reference to each case. In order to do this, the clinics must not only maintain but increase the ratio of staff to patients. The future will undoubtedly demand more and more that clinic staff be used in the training of others outside the Foundation who are working in the field of alcohol addiction. *(Page 25)*

Treatment and Referral Statistics

Treatment statistics for the year 1960 have not changed greatly from preceding years. The number of different cases seen in 1960 totalled 1,797 (compared with 1,529 in 1959). New patients treated in 1960 totalled 1,001 (comprising 837

men and 164 women). The pattern of referrals of new patients was much the same as in previous years — 22 per cent from physicians, 15 per cent brought to the clinic by family or friends, 12 per cent from Alcoholics Anonymous, and 12 per cent self-referred. Referrals from industry, social agencies and clergy all showed marked gains in 1960, possibly reflecting educational work directed to these quarters. *(Page 34)*

The total number of admissions of Foundation patients to general hospitals was reduced in 1960, which is regarded as a reflection of the total demands being placed on general hospitals which now make the awarding of beds extremely difficult for the acutely ill alcoholic who is often prepared to wait only a few hours to obtain a bed despite the fact that people with greater degrees of illness must sometimes wait days before they can be admitted. As the superintendent of one community general hospital wrote: "The fact that our hospital is actually turning away daily both private and public as well as police emergency cases is no doubt a limiting factor on any positive approach by this hospital's medical staff to more extensive admitting of alcoholic patients." *(Page 27)*

Patients Treated by Foundation Clinics in 1960

	Toronto	London	Ottawa	Hamilton	1960 Total
Total number of different cases seen	1,023	261	226	287	1,797
Patients from previous years	496	126	102	72	796
New patients in year 1960	527	135	124	215	1,001
New male patients of 1960	437	111	99	190	837
New female patients of 1960	90	24	25	25	164
Local residents treated in 1960	424	92	110	178	804
Out-of-town patients treated in 1960	103	43	14	37	197

Primarily for learning and teaching purposes, the Foundation has operated a variety of small treatment services in four Ontario cities. Those patients who have come to these services seeking help have consistently received the best service that could be provided by the staff with the facilities they have had. Fortunately the Government of Ontario has seen fit to support the Foundation's policy on the relationship of its treatment services to research. Without such support the pressure that exists for expansion of treatment services in this field might well have so hampered the research program as to have prevented any real progress toward an understanding of alcohol addiction. *(Page 14)*

Up to 5% of Ontario Adults May Become Addicts

Forecasting future requirements for the treatment of alcohol addiction is difficult because a great many variables are involved. However, if present trends continue, by the end of another decade somewhere between 2½ and 5 per cent of Ontario's adult population is likely to be addicted to alcohol.

A blueprinting of future treatment needs must include a careful study of how existing health and welfare resources can make their most effective contribution. Important existing resources include the province-wide network of Alcoholics Anonymous, individual physicians in private practice, in industrial medicine and in public health work, such special services as Salvation Army Harbor Light, the Department of Reform Institutions' Alex G. Brown Memorial Clinic, and the Bell Clinic, as well as institutions which have other primary purposes but which incidentally find themselves dealing with a fair number of alcohol addicts (provincial mental hospitals, tuberculosis sanatoria, psychiatric hospitals and general hospitals, mental health clinics, and various community social agencies). *(Page 15)*

Consulting Role for A.R.F. Clinicians

In the future, Foundation clinicians may find themselves dealing increasingly with those cases which present difficulties beyond the scope of the more general health and social agencies, and also serving as consultants to other treatment personnel. The Ottawa branch is already establishing a regular travelling consultation service to social and other health agencies in rural areas of eastern Ontario at

some distance from the capital; and the social worker attached to the London branch is making a special effort to attend staff conferences of other community agencies and to invite their staff to make reciprocal visits to discuss specific cases. *(Pages 16 & 35)*

Could Be Treated in TB Sanatoria

More and more it is being realized that successful treatment of an addiction may be essential to success in treating certain other illnesses, such as tuberculosis, which may on the surface appear quite unrelated to the addiction. Recognition of this fact by tuberculosis treatment personnel could greatly augment Ontario's resources for treating alcohol addiction without enlarging present specialized facilities. What is needed, as in many other areas, is more trained staff. *(Page 16)*

Since it is generally believed that success in treatment is more likely when an addiction problem is recognized and treated before it has progressed too far, it is to private physicians, to nurses and physicians in public health and industry, and to such people as clergymen, lawyers, and social workers that one must look for perhaps the largest and most effective contribution. *(Page 16)*

Handling Alcohol Addiction in Industry

It is particularly important that such professionals who work in industrial settings should seek to influence management policy toward intelligent handling of the worker whose job performance shows signs of suffering from alcohol addiction. Once such an employee is clearly recognized, he needs a frank, positive statement from his boss pointing out in sympathetic but unmistakable fashion how the drinking is interfering with the job, and offering in a way that cannot be misunderstood to keep the man or woman employed — on the sole condition that he or she accept and cooperate in a recommended course of treatment considered by competent people to be appropriate for that individual.

Experience in many large companies has shown that this type of positive, understanding policy toward alcohol addiction has saved them money in terms of reduced personnel turnover and employee training costs, improved worker morale and production, lower absenteeism and accident rates. Larger

industrial organizations have the resources for comprehensive health services under their own roof, but for smaller companies some kind of cooperative industrial consulting service and referral setup is worth considering, perhaps in conjunction with an existing addiction clinic, mental health clinic, or a panel of physicians or social workers. *(Pages 16 & 17)*

Two-Pronged Education Job

Speaking very broadly, the Foundation's education plan for Ontario has two main parts — general enlightenment of the public at large with regard to the avoidance or resolution of alcohol problems; and instruction of the various treatment professions in the treatment and rehabilitation of alcoholic patients. These are not mutually exclusive, but overlapping and interdependent; and what is said to each must be complementary to the other. The organization of professional training programs and the creation of teaching aids for treatment personnel is one of two main duties of the education department, the other being public education of a broader nature. *(Page 45)*

There is Much to be Told

In the education of the public about alcohol problems, the Foundation believes that there are many Ontario residents of all ages who are still ignorant of both the short-range effects of drinking relatively small quantities of alcoholic beverages, and of the longer range effects of repeated heavy drinking. The awareness of these people has to be stimulated and their interest engaged by every available means so they will perceive the facts about alcohol as these apply to them. What is taught to young people in home, and school, and church, and what they learn by their observation of adults generally in relation to drinking is of critical importance today in Ontario where the rate of alcohol addiction is still on the increase. Although scientists are a long way from knowing all the facts about alcohol addiction, there is enough known today to provide effective cautioning information to all users of alcoholic beverages if what is known can be brought meaningfully to their attention. Within the limits of the resources available to it, the Foundation's education department is developing new and more effective techniques for bringing this message home. *(Page 41)*

Two New Projects Successfully Launched

During 1960 the Foundation underwrote two short experimental television films and through the cooperation of the Canadian Broadcasting Corporation was able to produce three more. All of these are currently showing on the television network across Canada and they have evoked strongly favorable reaction both in this country and in the United States. Another departure during 1960 was the publication of a comprehensive pocket book entitled "Reference Notes on Alcohol Problems" for the use of all who write or talk about any aspect of this complex subject. Published late in the year, the demand for copies has already far exceeded expectations. *(Pages 42 & 43)*

A Canadian Alcoholism Research Organization

In education and research related to alcohol addiction there are many things which cannot be conveniently or economically done by provincial organizations, particularly those in the smaller provinces. As a result of this there have been negotiations in recent years toward the formation of a Canadian organization in this field. Substantial agreement has now been reached on the purposes and nature of such a national body and it is expected to be chartered some time in 1961. Such an organization may be able to take over some of the publishing and public communications functions now being carried on separately, and this may in turn relieve the Ontario Foundation's education department of a considerable production load, thereby freeing some of its staff for expanded efforts to reach people and groups throughout this province. It is also hoped that a federal organization will be able to obtain financial support for research projects which do not appropriately fall within the sponsoring capabilities of any one province's alcoholism control program. *(Page 21)*

Chief Personnel of the Alcoholism Research Foundation

Following are the men responsible for directing the overall administration of the Foundation and for its work in the three areas of research, treatment, and education:

H. David Archibald, executive director
John D. Armstrong, M.D., medical director
Robert R. Robinson, director of education

Robert E. Popham, assistant research director (social sciences)
Harold Kalant, M.D., assistant research director (biological studies)
Charles H. Aharan, executive secretary, London branch
John A. Neilson, executive secretary, Ottawa branch
Gordon M. Patrick, executive secretary, Hamilton branch

This executive group carries out policies laid down by the Members of the Alcoholism Research Foundation under the chairmanship of Mr. I. P. McNabb, and with the advice of the Medical Advisory Board under the chairmanship of Dr. J. K. W. Ferguson.

Confessions of a Private Secretary

EDITOR'S NOTE: Much has been written and said about alcoholism in industry — by industrial physicians, personnel managers, representatives of organized labor, and by management people concerned with production efficiency and costs. Little, if anything, has been put in print by the kind of person who knows most about the habitat and habits of organization man, his secretary.

What follows is a start toward making up this deficiency.

"It's all true," she says, "but I changed the settings around to protect myself. After all, most of these men I'm writing about are still rocking the boat today!"

• • •

I'M ONE of industry's well trained secretaries— trained in the art of running interference for a business executive. I'm an employee of a large and widespread firm. My boss is a lawyer with a drinking problem. He's asleep in his office with the door closed—or maybe he hasn't come in at all. You have to get by me to get to him—he's Somebody in this firm. Watch me run interference for him.

"I'm sorry, Mr. Scotch is tied up for a while and I've been instructed not to disturb him. I'll have him call you when he's free."

The phone's ringing—it's the Big Chief's secretary and he wants to see my boss. I can't use the same routine for this one.

"Mr. Scotch isn't in right now, Miss Beer, he had to go to the Land Titles Office (or the Court House). I'll try and locate him for you and give him the message."

These calls from the Big Chief aren't as difficult to handle as you might suppose. He's always getting tied up himself which gives me that precious time I need.

It's ringing again. "I'm sorry, Mr. Scotch is out right now. I'll have him call you as soon as he gets in." That was his wife—guess he didn't get home last night at all. I know she's

been covering up for him some mornings when I tried to locate him. She must think I'm awfully dumb—I know a hangover when I see one. Listen to some of the yarns she gives me.

"My husband asked me to call you and tell you he'll be a little late this morning." (Well-trained secretaries never ask why.)

"My husband isn't feeling too well this morning—I guess it must be a touch of the 'flu. He'll try to make it in later."

"My husband has an upset stomach this morning—he wasn't even able to keep his breakfast down. He'll try to make it in later."

Sometimes I call her back when I get a little desperate and ask to speak to him. Listen with me. "He's resting right now and I'd rather not disturb him. May I give him your message?" I give her one. Glance up with me and see him coming in the door—he wasn't even there.

It's more difficult when the same person calls two or three times. I have to change my line a little. "Mr Scotch did call in (or drop in) but he had to leave right away for a meeting—he didn't say where (or I forgot to ask him) but I gave him your message and he asked me to extend his apologies. He'll call you the first possible moment."

I'm worth a lot of raises to this boss and he knows it. Why shouldn't I do my duty?

• • • •

SIT with me in my new job. A message comes in—some pipe from the yard is needed in another locality and the load must roll. The fellows who handle this aren't available and I don't know one piece of pipe from another, but I know where to go for help. My firm is a major account with a company that understands about pipe. Listen while I phone and a man tells me he and a fellow worker will be glad to help out. They know the trucking firm we sometimes do business with—they'll even look after that because I don't know what size truck we need.

Listen a short time later in my office while the fellow who understands about pipe gives the trucker the business. Watch him wink at me and tell the trucker he ought to be

glad to buy a round—a round of bottles, that is—in appreciation for the job. Come to the nearest liquor store with us and wait while the trucker goes in and buys four—he got one too. Laugh with us when he says, "Don't worry, Girlie, I'll get it back."

Take dictation with me next day when that fellow who understands about pipe walks in to see if everything was in order. Watch him wink at me while he gives my boss the business. Good job like that ought to be worth a jug. My boss figures it ought to be worth two. I haven't got a drinking problem, but the fellow who understands about pipe has and it cost my firm six jugs that I know of. I went over and got the other two.

• • • •

SIT with me in another office. It's time to make up the expense accounts. Watch us pad them. Where are the receipts for the sleeping accommodation? The boys didn't sleep there, of course — some of them partied all night and some of them stayed with a friend. I don't know if all these men have drinking problems, but the fellow supplying the receipts has—you can get one if you buy him a drink. This kind of news travels fast among the boys on the road.

Listen with me while they select the names of those they entertained. Cementing company relations, of course, and you can't cement them without a bottle. The company will pick up the tab.

• • • •

MY roommate works for a doctor. He has a problem too, but she tells me it's a cinch in the medical game. The doctor can always be on call—or an emergency—or a maternity case — or an operation. Listen while she tells me people are used to waiting in a doctor's office—they don't even suspect.

Sit with us on a party one night and listen while a bunch of the boys who work together laugh about the time they're getting off with pay because they supplied the doctor's certificate the company requires. They think the doctor's a good head. I don't know if all these men have drinking problems,

but the doctor supplying the receipts has—he's the one my roommate works for. News like this travels fast in the bars.

• • • •

MOVE into a furnished house with me and three of my girl friends. We all work in different offices but we're connected with the same industry. Listen while we tell each other about some of the things we've never heard of.

—Never heard of a business executive going out for lunch to the club unless he had some drinks—paid for directly or indirectly by the company.

—Never heard of a company-organized bowling, golfing or curling outing where there wasn't liquor.

—Never heard of a company-organized banquet or dance where arrangements weren't made for a bar.

• • • •

SIT with us one morning after a party at our place. If the hangovers are just little ones and all we need is a little more time for black coffee, we use the same excuses the fellows do—alarm didn't go off, missed the bus, or slept in. This party was an extra late one and we really could do with half a day. Listen to us phone the office. We make it a point to get a man. We don't say we have a hangover and of course we can't out and out say it's the wrong time of the month. We say things like "Well, Mr. Rye, I don't know just how to explain this, but it isn't something I won't get over." The men catch on quickly and this subject is just too, too delicate for a man to pursue further. It works every time. Laugh with us while we pile back into bed.

The Role Of The Nurse In Treatment Of Alcoholics

By Betty Kinch, R.N.*

IF THE nurse in a general hospital is to do her best for the alcoholic patient, she must understand the important part which her position enables her to play in directing the recovering patient into follow-through therapy. His period of hospitalization is only the beginning of treatment for alcoholism.

We still see nurses who have much difficulty in accepting the alcoholic as a sick person, who are still seeing him as a weak individual with no will-power and consider him a nuisance to hospital staff. The nurse must be able to accept him as he is, and this requires much patience and understanding.

The nurse is probably first going to see the alcoholic patient in the emergency or admitting department. He may be in a very intoxicated state, or he may be sober. Regardless of his condition, he is probably a very frightened and anxious person, even to the extent that he may find it impossible to remain for treatment. There is the fear of drinking but also the fear of sobriety. Any patient has feelings of insecurity and fear and it is very frightening to suddenly find himself in a situation over which he has no control.

Reassurance and Help

Our role is to decrease the alcoholic's anxiety by offering him reassurance and help, as we would to any other sick person. We may see a patient who is dirty, frightened, anxious, hostile, disturbed, and disturbing to all concerned. He may be a nuisance, exhibiting very bizarre behaviour, and he may be extremely difficult to control, someone the nurse would rather avoid than approach. So often we will see the alcoholic reacting quite violently and with much hostility towards the person who has brought him to hospital, sometimes against his will.

When confronted by the nurse, who is able to handle her own feelings around this patient's behaviour, it is usually quite amazing to observe the change in his behaviour. To this dis-

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* Miss Kinch is Nurse Instructress at the Toronto Clinic of the Alcoholism Research Foundation. This article is abridged from one she presented, on invitation, at a nurses' conference in Massachusetts.

turbed individual she seems to represent a figure who can understand him as a sick person, one who wants to help him, but the nurse must make this known to him.

May Influence Return

We find some patients presenting themselves in the emergency department who may not be ready to involve themselves in treatment. They may be quite ill, but just asking for some medication to get them comfortably through a temporary withdrawal from alcohol. They may have some reservations about their drinking problems; but the nurse, through encouragement and understanding, may be influential in their returning for treatment at a later date.

The nurse should know about the D.T.'s — the severe and complicating problem of acute intoxication. Jokes about pink elephants notwithstanding, there is nothing funny about the D.T.'s. The patient may show confusion, extreme aggressiveness, lack of co-operation, hallucinosis and sometimes epilepsy, developing this either while still drinking or after the beginning of withdrawal. It is important for the nurse to observe the patient closely and to record these symptoms in order that his withdrawal may be handled safely and adequately by the doctor. If the patient is experiencing any of these symptoms the nurse can help by understanding his symptoms and fears and how very real they are to him. She must attempt to convey this understanding and reassure him, realizing that his fears will be greatly increased by solitary confinement and by the use of restraints. These measures should only be employed if the patient is a threat either to himself or to others.

A quiet, understanding atmosphere is most helpful in bringing the patient back to the reality situation. Present-day medications control the person with the D.T.'s very effectively and usually he responds quickly. As nurses in the general hospital, you will be seeing a number of patients with the D.T.'s since this is one of the reasons for admitting the intoxicated person. From this, they may wrongly assume that most alcoholics develop the D.T.'s. It is a fact, however, that only about 5% of the alcoholic population experience these.

The patient's withdrawal is handled with drugs, but only during the immediate recovery stage. The drugs are helpful

in reducing his irritability and restlessness. Regarding the use of drugs, nurses must realize that these patients have an addictive illness and that because of their addiction they are very prone to substitution.

At no time should the alcoholic be given large quantities of barbiturates, paraldehyde, bromides or tranquilizers unless it is felt that he can adequately handle them as directed by the doctor. The alcoholic should be made to understand this part of his illness, and it is the role of the nurse to help him to accept the early discontinuance of drugs following his withdrawal and to recognize the dangers of developing drug addictions. Many alcoholics complain of sleeplessness and therefore feel they have a great need to take sleeping pills. The nurse must help the patient to understand that this is a temporary discomfort following withdrawal and that it would be more dangerous for him to continue on drugs.

Ward Setting

It is not every patient who, once he is dried out, wishes to involve himself in on-going therapy; but for those who do wish to continue in treatment, the ward setting is important. When alcoholics are treated in a setting with other illnesses, many do not feel free to discuss their alcoholism. They need to learn to communicate their feelings and to be accepted by people, but are unable to do this with inexperienced staff and unsympathetic patients. Too little opportunity is available to learn to understand the illness and something about the patient. Although I feel that the separate unit is the most desirable for the treatment of the alcoholic, it is not always possible, nor should it prevent any nurse from playing an important role in helping the alcoholic.

A rigidly regulated ward setting, where the nurse is the authoritarian figure and where patterns of conformity are usually enforced, is a poor setting for the alcoholic patient, who has usually built up a great deal of resentment towards authority and towards the enforcement of rules and regulations. The nurse should realize that the patient community needs *postive* discipline. Some nurses have very rigid attitudes towards discipline and enforcement of regulations; but in this situation the nurse should be flexible and have a ready response to patients'

requests. At the Toronto hospital of the Alcoholism Research Foundation we have as few rules and regulations as possible and our patients are allowed considerable freedom. Certain rules have been made, some as a protection and some in order that therapy can be carried out under the best possible conditions. A patient may request permission to leave hospital for various reasons — to seek employment, for a haircut or perhaps just to buy a package of cigarettes. Sometimes there is no real reason for him to be refused; but the nurse does refuse him or she may refer him to some other member of staff. It is difficult to persuade some nurses to make their own decisions and rather than accept the responsibility for allowing a patient to go out, she will refuse his request.

We should be aware of the reasons why some nurses are reticent to accept this responsibility. Often the nurse is trying to protect the patient, fearing he may drink while away from hospital, or she may fear criticism from other staff members for her decision, but she must have confidence in her own good judgment and always be aware that whatever her decision, it was made for the good of the patient. Some patients will go out and get into drinking difficulties but the nurse must understand that her patients are not always going to be in the protective setting of the hospital. Some patients have to test out their drinking and many benefit from such an experience and are often better able to understand the compulsive part of their addiction. The nurse must learn the skills of handling situations so that her decision may not be viewed by the patient as hostility or weakness on her part.

Opportunities to Communicate

We often see nurses who are guilty of adopting a very efficient routine. More importance is placed on the expediency of carrying out nursing procedures than on the patient who is involved in these procedures. Rather than hiding behind such routine, the nurse must be aware that these occasions are opportunities to communicate with him. The atmosphere of hurriedness may be the nurse's idea of efficiency but would certainly appear to interfere with the establishment of satisfactory interpersonal relationships with patients. Many nurses feel most uncomfortable when they are just talking with

patients because so much emphasis has been placed on being busy. Often such nurses are far from being busy, but an impression of 'busyness' has been effectively established. As Dorothy E. Gregg has said in her paper on the Psychiatric Nurse's Role — "The patient who feels unworthy and disrespected may need the experience of learning personal worth. The nurse may convey a feeling of respect and an impression of his personal values as she carries out her nursing procedures. Through her manner as well as through verbal communication in these contacts, she can provide the patient with the experience of being accepted".

Whether the nurse is only seeing the alcoholic for a short term or on a long-term basis, any contact which she has with the patient is important and she must be aware of what her behaviour can convey to him. Sometimes the nurse may move away from situations that are uncomfortable, and this is a readily available defence to her. Although she may try to avoid the patient whose behaviour is bizarre, erratic or hostile, she must have some understanding of the meaning of this behaviour in order to share her observations with other staff members, realizing that in many instances they rely on her information.

Least Threatening of Staff

The patient probably sees the nurse as the least threatening of all the staff. He sees the other members of the staff usually in the formal office setting which is in itself, a certain threat to him, whereas he is seeing the nurse in the less formal setting of the ward. The patient sees the nurse as non-judgmental, non-critical, accepting him as a sick person who can be helped. The nurse must understand what the patient is really seeking. He is seeking someone with whom he can talk freely without fear of criticism and with whom he feels comfortable; someone with whom it is safe to allow a relationship to develop; one who is understanding, patient and tolerant. The nurse with experience should be able to fulfill these requirements. The alcoholic has a great need for acceptance and should come to know that he is accepted and respected by the nurse as a person in his own right. She should encourage him to communicate his feelings, to examine his thoughts, actions and problems, that his needs can be recognized. The greatest part of the nurse's role is the support and encouragement that she can give him.

Role of Protective Drugs

Often, in the rehabilitation of the alcoholic, the use of a protective drug plays an important part. The nurse should understand the action of the protective drugs and be able to point out to each patient their usefulness in the treatment of alcoholism. The nurse must understand that any protective drug must be given at the request of the patient, that at no time should it be forced upon him, nor should it be given without his knowledge.

The taking of such a drug does not in any way replace the need for active participation in other aspects of a rehabilitation program, including association with Alcoholics Anonymous or other phases of the follow-up program at the clinic itself. Although it is not every patient who may choose a protective drug or who feels it a necessity, the nurse can help each patient to accept that these drugs can play a very useful part in rehabilitation. This is when the patient must be made to realize that his recovery from alcoholism should be thought of as a long term proposition. He must understand that his use of alcohol is only a symptom and a complicating factor of his illness and that adequate and sustained treatment and follow-up therapy are indicated for a good recovery. His sobriety is only one part of his treatment and is necessary for him to look at his problems and to start a rehabilitation program.

On discharge a patient that a nurse has tried to help may appear to be making considerable progress in his rehabilitation; but perhaps before long he returns, apparently back where he started from. This is where the nurse must look at his recovery in terms of degrees of improvement. The nurse must understand that many patients seem to have to test out their drinking again. She must also realize that perhaps this is the first time this person has ever tried to stop drinking and that any period of sobriety is some improvement. Here the nurse can encourage the patient by pointing out this improvement and showing him that although he has had a relapse, at least he has returned for further treatment and she is willing to support him in his increasing sobriety.

The nurse, of course, is going to see many repeaters, perhaps some whom she has come to know quite well, whom she

wants to help, and with whom she can sympathize. Here we see nurses who get 'caught up' in their own feelings, where they want so badly to do something for this individual but where feelings should not take the place of better judgment. This is where limits must be put on the individual patient. Admission may not always be possible or advisable in that a dependence on the hospital is being fostered, encouraging him to repeat performances. Although it is sometimes difficult to do when the patient who is drinking has sought out a particular nurse, it is necessary for that nurse to make the patient understand that she is available to help him in his recovery but not to support him when he is drinking. She must always try to be consistent in putting limits on a patient who is still drinking, but in such a way that it will not be interpreted as rejection. She should convey to him an obvious sense of caring but at the same time help him to understand that no rehabilitation can be started until he has his sobriety.

Often In For Other Reasons

There are many times when the nurse is going to encounter the alcoholic in the general hospital although he may be presenting himself with some other illness or injury. In this situation the nurse with experience can play an important role, even though it may be impossible to build up an intensive treatment relationship. We sometimes see a patient admitted to either medicine or surgery and during his hospitalization we find that he is very dependent on alcohol, to the extent that it may be interfering or preventing recovery.

Increasingly, too, alcoholism is being seen among patients in tuberculosis sanatoria. If the doctor or the nurse were experienced in this field, he or she, through gaining the patient's trust, could easily approach him and help him to bring his problem into the open. Actually these people are often sicker with their alcoholism than with the illness for which they have been admitted, and yet we still see nurses and doctors going blindly on, not even wanting to recognize the problem, let alone wanting to do anything to help.

As an example, I would like to tell you an experience of one of our patients. He had had a severe drinking bout, was afraid he was going to develop the D.T.'s, and decided to go

to the emergency department of a large general hospital. On arrival, he was obviously intoxicated and extremely anxious and decided that he would probably not get any attention if the doctor or nurse thought he was, as he called it, 'a drunk'. Therefore, he decided to tell them he had a sore back. The back was examined and, of course, nothing was found to be wrong. He was told it was his 'nerves', was given a substantial supply of barbiturates and sent on his way. Not only is this a dangerous practice, but it would certainly indicate anxiety on the part of both doctor and nurse in aproaching this patient regarding his drinking problem.

Any doctor and nurse should be able to approach an obviously intoxicated patient in a hospital and at least offer him help. We cannot at any time, disregard the symptoms of alcoholism. Perhaps the patient isn't ready to stop drinking or to involve himself in treatment immediately, but with some interest and understanding from the nurse he will know that here is a place where he is accepted as a sick person and a place where he can eventually receive treatment.

List Research Reports on Alcohol Subjects By Staff, Students and Grantees of Foundation

A. Experimental Studies of Ethanol Metabolism, and of the Physiological and Behavioural Effects of Alcohol

TITLE	AUTHOR	WHERE PUBLISHED
Metabolism of C^{14} Ethanol by Surviving Rat Tissues.	Abramovitch, H. & Birchard, J.R.	Amer. J. Physiol. 173: 37-40, 1953.
The Effect of Acute Alcoholic Intoxication on Adrenal Ascorbic Acid and Cholesterol in the Rat.	Czaja, C. & Kalant, H.	Can. J. Biochem. & Physiol. 39: 327-334, 1961.
Alcohol and Experimental Neurosis in Cats: Some Ruminations.	Smart, R.G. & Vogel, M.D.	A.R.F. Substudy 1-6 & 7-59.
The Influence of Alcohol upon Carbohydrate Metabolism in the Liver and in Isolated Diaphragms.	Clarke, D.W. & Evans, R.L.	Quart. J. Stud. Alc. 21: 13-22, 1960.
Effects of Aliphatic Alcohols on the Metabolism of Brain and Liver.	Quastel, J.H.	Quart. J. Stud. Alc. 20: 428-431, 1959.
Toxic Joint Action of Ethanol and Barbiturates.	Aston, R.	Ms. on file, A.R.F. 1957.

B. Studies of Relations Between Alcohol Consumption, Alcoholism and Various Organic Disorders

Alcohol-Epilepsy Link Still Uncertain.	Smart, R.G.	Alcoholism 5(1): 17-20, 1958.
The Macrocytosis of Hepatic Disease.	Bingham, J.R.	Blood 14: 694-707, 1959, and also Blood 15: 244-254, 1960.
Fat Embolism in Chronic Alcoholism.	Lynch, M.J.G. et al.	A.M.A. Archives of Pathol. 67: 68-80, 1959.

The annual report contains a complete cross-indexed directory of all research projects undertaken or sponsored by the Foundation since it was established. On succeeding pages of this issue of Alcoholism is a smaller list, extracted from the annual report, of the principal reports on these projects, either published or on file.

TITLE	AUTHOR	WHERE PUBLISHED
Further Studies in Chronic Alcoholism.	Raphael, S.S. et al	Can. Med. Assoc. J. 82: 16-20, 1960.
Brain Lesions in Chronic Alcoholism.	Lynch, M.J.G.	A.M.A. Archives of Pathol. 69: 342-353, 1960.
Precipitating Factors in Peptic Ulcer.	Bingham, J.R.	Can. Med. Assoc. J. 83: 205-211, 1960.

C. Studies of Drugs for the Treatment of Alcoholism and Acute Alcoholic Intoxication

The Use of Lipotropic Factors in the treatment of Alcoholism.	Armstrong, J.D. Bingham, J.R. Gibbins, R.J. & Kerr, H.T.	Can. Med Assoc. J. 75:198-201, 1956.
A New Drug for Alcoholism Treatment	Ferguson, J.K.W. Armstrong, J.D. Kerr, H.T. & Bell, R.G.	Can. Med. Assoc. J. 74: 793-798, 1956.
Effects of Cyanamide and Ethanol on Bleeding	Warson, M.D. & Ferguson, J.K.W.	Quart. J. Stud. Alc. 16: 607-613, 1955.
Weights and Blood Acetaldehyde in Mice and Rats		
The Protective Drugs in the Treatment of Alcoholism	Armstrong, J.D.	Can. Med. Assoc. J. 77: 228-232, 1957.
A Search for Drugs with Disulfiram-like Activity.	Boyd, E.M.	Quart. J. Stud. Alc. 21: 23-25, 1960.
Development and Testing of Substitutes for Disulfiram in the Treatment of Alcoholism.	McCurdy, D.H.	Ms. on file, A.R.F. 1957.
Alterations of the Reaction to Ethanol Induced by Cyanamide and Other Compounds.	Aston, R.	Ms. on file, A.R.F. 1956.
Observations on the Treatment of the Acute Alcoholic.	Park, A.M. & Bedwell, S.F.	Can. Med. Assoc. J. 75: 406-411, 1956.

D. Other Studies Concerned with the Clinical Treatment of Alcoholism

The Significance of Tension Change in Alcoholism.	Smart, R.G.	A.R.F. Substudy 3-7-60.
Effects of Clinical Treatment on Behaviour of Alcoholic Patients: An Exploratory Methodological Investigation.	Gibbins, R.J. & Armstrong, J.D.	Quart. J. Stud. Alc. 18: 429-450, 1957.

The Association Between Motivation for Seeking Treatment and Treatment Outcome in a Sample of Alcoholic Patients.	Neilson, J.A.	M.S.W. Thesis, U. of Toronto (Social Work) 1956.
The Relation Between Social Participation and Drinking Before and After Treatment in a Sample of Alcoholic Patients.	Schmidt, W.	M.S.W. thesis, U. of Toronto (Social Work) 1957.
A Psychotherapeutic Technique with Large Groups in the Treatment of Alcoholics: A Preliminary Report.	Armstrong, J.D. & Gibbins, R.J.	Quart. J. Stud. Alc. 17:461-478, 1956.
The Protection Client Who Drinks to Excess.	Barnes, J.	M.S.W. thesis, U. of Toronto (Social Work) 1957.
Psychological and Social Factors in the Rehabilitation of the Alcoholic.	Deschamps, C.	U. of Ottawa (Social Work) 1955. M.S.W. thesis.
Some Comments on the Proposed Habitué Act.	Seeley, J.R.	A.R.F. Substudy 20-1-59.
The Relationship Between the Drinking Pattern of Alcoholic Patients and their Employment Pattern Before and After Treatment.	Dastyk, R.	U. of Toronto (Social Work) 1957. M.S.W. thesis.
A Study of the Relationship Between Drinking Behavior and Participation in Child Care Activities of a Sample of Alcoholic Patients Before and After Treatment.	Jackson, M.J.	M.S.W. thesis, U. of Toronto (Social Work) 1958.
Research Design in the Evaluation of Hypnotherapy.	Paul, J.	J. Clin. & Exp. Hypnosis 6(2): 71-82, 1958.

E. Studies of the Psychological Characteristics of Alcoholics and of Psychological Factors in the Development of Alcoholism

A Comparative Study of the Self-Concepts of Alcoholics and Non Alcoholics.	Aharan, C.H.	M.A. thesis, U. of Western Ontario (Psychology) 1952.
The Revised Bender-Gestalt and Male Alcoholics.	Story, R.I.	J. Projective Techniques 24: 186-193, 1960.

TITLE	AUTHOR	WHERE PUBLISHED
Measuring Hostility in Alcoholics.	Egener, K.C.	M.A. thesis, U. of Western Ontario (Psychology) 1953.
Study of a Prison Aggression Group.	Henheffer, B.W.	M.A. thesis, Queen's U. (Psychology) 1952
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A.R.F. Activity News

SPRING 1961

Third reading has been given to the **Bill to Amend the Alcoholism Research Foundation Act**, which bill extends our terms of reference to include research on addiction to substances other than alcohol. In due course, after this bill has received royal assent and has been proclaimed, the Foundation's name will be changed to the **Alcoholism and Drug Addiction Research Foundation.** At the same time, this quarterly publication **Alcoholism** will change its name to **Addictions.**

The Foundation has now signed a **contract with Lederle Laboratories** (the company producing Temposil, the protective drug developed in Toronto by researchers working on Foundation grants) for royalties from sales of this drug. These royalties are now being placed in a **trust fund to be used for international fellowships.** The first fellow to receive a grant from this fund will be **Dr. Hugo Solms** head physician of a university psychiatric clinic in Lausanne, Switzerland, and it will enable him to visit and work with the Foundation's clinic during a 6-month period beginning about June 1 of this year.

Effective April 1, **Dr. R. G. Birrell,** retiring medical director of Imperial Oil Limited, will join the staff of the Alcoholism Research Foundation as our **assistant medical director.** Dr. Birrell has a background of wide experience in surgery, industrial medicine, and medical education in Canada, U.S.A., Latin America, and China, and has for the past 13 years headed Imperial Oil's entire medical service organization throughout Canada.

Mr. C. Duncan, President of the Grocery Products Manufacturers of Canada, has been appointed one of the Members of the Alcoholism Research Foundation. There are also two new members on the Foundation's Medical Advisory Board, Dr. Jean F. Davey, and Dr. Wilfred E. Boothroyd. Dr. Davey is an internist, Dr. Boothroyd a psychiatrist, both in practice in Toronto.

Mr. D. F. Hassel, vice-president of Dominion Foundries and Steel Co. Ltd., has been elected Chairman of the Hamilton Board of Trustees, succeeding Mr. R. J. Sazio, for whose services, during the past very demanding year of growth in the branch, the Foundation is deeply appreciative.

Two new research grants were recently made by the Foundation:

(1) to Dr. Hugh Campbell (psychology) and Dr. S. G. Laverty (psychiatry), Queen's University, for investigation of conditioned aversion responses in relation to their use as a treatment for alcoholism. This is a further step that follows logically from Dr. Muriel Vogel's studies on introversion-extraversion and conditionability.

(2) to Professor C. C. Lucas in the Banting and Best Department of Medical Research for a study of the possible protective effects of dietary protein in alcoholic rats.

A conference on research and public information in the field of alcohol and road traffic is being held in Pittsburgh, May 22-24. Dr. Wolf Schmidt of the Foundation's research staff is giving one of the papers at this conference, and two other representatives of the Foundation will attend as well.

At the request of a student committee representing 125 seminarians in training for the priesthood at St. Peter's Seminary, London, Ontario, a two-day study program on alcohol addiction took place February 7 and 8. In addition to Messrs. Charles Aharan and Ken Green of the London branch staff, Dr. E. M. Jellinek and Bob Robinson from Toronto took part in the program. St. Peter's is one of two seminaries in Ontario training Roman Catholic parish priests.

The Alcoholism Research Foundation was established in 1949 by an act of the Ontario Legislature. It is financed largely by an annual government grant. The Foundation is empowered to (a) conduct and promote research in alcoholism; and (b) conduct, direct and promote programs for (i) the treatment of alcoholics, (ii) the rehabilitation of alcoholics, (iii) experimentation in methods of treating and rehabilitating alcoholics, and (iv) dissemination of information respecting the recognition, prevention, and treatment of alcoholism. Treatment through the Foundation is available to any resident of Ontario who has a problem with alcohol and an honest desire for help in solving it.

Addictions